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NURSING HOME INSPECTIONS: NEW JERSEY

ORIGINAL

COMPLETED

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

JULY 16, 1982

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CONTENTS

Members' Opening Statements

	Page
James J. Florio	1
William J. Hughes	3

Chronological List of Witnesses

Shirley A. Mayer, M.D., MPH, Commissioner of Health, State of New Jersey; accompanied by Frederick F. Hebeler, Director, Health Facilities Inspection Services	4
Thomas G. Morford, Director, Office of Standards and Certification, Health Standards and Quality Bureau, Health Care Financing Administration, Department of Health and Human Services; accompanied by James J. Conrad, Chief, Financial and Administrative Management Branch, Office of Standards and Certification; and James Morris, Principal Program Representative, Bureau of Health Standards and Quality, Region II, Health Care Financing Administration	9
John J. Fay, Jr., New Jersey Ombudsman for the Institutionalized Elderly; accompanied by Stuart Weiss, Executive Director	20
Betty Rice, Camden County Nursing Home Ombudsman	24
Jacqueline Vogelmann, Director, Nursing Home Advocacy Center of Essex County	25
Margaret Luck, Community Service Outreach Officer, Camden County Health Services Center	31
Barbara Frank, Director, Information Clearinghouse, National Citizens Coalition for Nursing Home Reform	34
Barbara W. Wright, R.N., Executive Director, New Jersey State Nurse's Association	73
Sybil Shainwald, Chair, Board of Directors, National Women's Health Network	74
Paul Mullen, Director, Government Relations, Joint Commission on Accreditation of Hospitals	78
James E. Cunningham, President, New Jersey Association of Health Care Facilities	87
Dennis R. Hett, Executive Director, New Jersey Association of Non-Profit Homes for the Aging	92

Appendix

Additional material received for the record:	
Louise Meyer and Mildred Jones, Shady Lane Home, Clarksboro, N.J., joint letter	99
Eleanor S. Rubin, President, Senior Service Corps, Orange, N.J., letter	99
Louis P. Scibetta, F.A.C.H.A., President, New Jersey Hospital Association, Princeton, N.J., letter	100
Gertrude Koerner, Volunteer State Ombudsman, Camden County Office on Aging, letter	101
George J. Albanese, Commissioner, Department of Human Services, State of New Jersey, Trenton, N.J., letter	101

NURSING HOME INSPECTIONS: NEW JERSEY

FRIDAY, JULY 16, 1982

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Gloucester Township, N.J.

The committee met, pursuant to notice, at 9:40 a.m., in the Student Community Center, Camden County College, Gloucester Township, N.J., Hon. James J. Florio, presiding.

Members present: Representatives Florio of New Jersey and Hughes of New Jersey.

Staff present: David W. Higham, legislative assistant to Congressman Florio.

OPENING STATEMENT OF REPRESENTATIVE JAMES J. FLORIO

Mr. FLORIO. The committee will come to order.

I would like to welcome all the attendants here at Camden Community College in Gloucester Township.

I would express my appreciation to Dr. Otto Mauke, who I see in the audience, and all those who have made the facilities available to us.

Today's inquiry is a hearing by the House Select Committee on Aging of the U.S. House of Representatives. The committee chairman, the Honorable Claude Pepper, has authorized myself and Congressman William Hughes to convene this hearing for the purpose of reviewing proposals by the administration to relax minimum inspection regulations for nursing homes.

This morning's hearing is the first of a series of hearings to be conducted by the House Committee on Aging on the nursing home proposals.

Testimony submitted today and recommendations received today will be reviewed by the full committee and the House of Representatives, and will be, as are all select committee submissions, transmitted to the appropriate authorizing committees with any recommendations to be made by the Select Committee on Aging.

I am pleased that we intend to forward testimony from today to the U.S. Department of Health and Human Services in Washington, as well, who are responsible for nursing home proposals and who are now in the process of reviewing suggestions to the pending regulatory proposals.

With these preliminary announcements made, I would like to briefly summarize my concerns as to the nursing home proposals which are currently being evaluated. These proposals, in my opinion, would change Federal rules governing how nursing homes are to be inspected, the purpose of the inspections, of course, being to

insure that proper conditions are being met. They would also change the frequency and the quality of the inspections.

Some of the proposed changes are technical and administrative in detail. Other changes sought by the administration would significantly decrease the ability of the Federal Government and the States to insure that the health, safety, and comfort of nursing home residents is maintained.

The major changes under consideration would eliminate the Federal requirement that nursing homes cooperate with an unannounced Government inspection at least once a year; no longer mandate that nursing homes be reinspected within 90 days when the home has been found deficient during a previous inspection; and allow States to substitute the Government's nursing home inspections for that of a private organization, with no guarantee that the results of their inspection will be fully accessible to the public.

The administration believes that these changes are desirable so that State governments can exercise greater discretion in enforcing State nursing home operating standards. By not requiring every nursing home to be inspected at least once a year, the administration believes that greater attention and more frequent inspections can be aimed at nursing homes with a history of poor conditions.

While agreeing with the goal that substandard nursing homes should receive the greatest attention and help from the Government until deficiencies can be corrected, or the facility closed down and the patients moved elsewhere, there are some difficulties with the approach that the administration has taken.

A basic inconsistency in the administration proposal is that while the Government seeks to give the State governments greater latitude in targeting resources to correct the worst nursing home conditions, the administration is making these resources less available. The administration's nursing home proposal is very much in step with the whole concept of the so-called New Federalism, where State and local governments are asked to carry out greater public responsibilities with inadequate funds to carry out those jobs.

In the last 2 years, Federal funding to inspect nursing homes in New Jersey has been reduced 52 percent. In March 1981, the Federal administration advised all State governments to prepare for the funding cut by stopping fire-safety inspections at nursing homes; using smaller, less specialized teams to inspect nursing homes, and eliminating on-site reinspections of nursing homes to make sure that reported problems have been corrected.

The administration is now seeking to incorporate these policies into permament regulations.

Faced with decreasing Federal help, New Jersey and other State governments may not have the ability to insure that nursing home patients receive proper, caring attention. Complex social, economic, and medical developments have blessed nearly every American community with an increasing proportion of elderly citizens.

During the last decade, the number of New Jerseyites over the age of 75 increased 22 percent. Many of this group will require a nursing home bed and join an increasingly vulnerable portion of our population. Almost all nursing home residents have serious health problems or require mandatory nursing care. Few can walk, most are disabled, and few of them have any visitors at all. Only 20

percent who enter a nursing home will ever return to their own homes.

The purpose of today's hearing is to make suggestions to those addressing the problem. We have a lengthy list of witnesses who, I am sure, can contribute much to the committee's store of knowledge. I am sure we are going to have some very good ideas.

I would like at this point to recognize my cochairman for today's hearing, a valuable member of the Select Committee on Aging, the Honorable Congressman William Hughes.

STATEMENT OF REPRESENTATIVE WILLIAM J. HUGHES

Mr. HUGHES. Thank you, Mr. Chairman.

Good morning. I, too, am just delighted to join you at this beautiful and prestigious facility known as Camden Community College. This is my first visit to the college and I am very much impressed.

Since 1966, the Federal Government has assumed a growing role in assuring quality care to our Nation's 1.3 million nursing home residents. Increasingly, our Nation's senior citizens who have spent their lives contributing to this Nation have come to rely on the Federal Government to guard their life and safety should they need institutional care.

The Congress and preceding administrations have responded to this trust by consistently improving the standards of care which must be provided to nursing home residents. On May 27 of this year, however, the Department of Health and Human Services proposed changes in nursing home inspection and certification standards which some experts believe to be a betrayal of the trust bestowed by older Americans in the Federal Government.

Instead of pushing forward to correct abuses, some believe the HHS proposals would take the teeth out of Federal regulations, leaving the Government a helpless observer to the abuses of the rights and care of the elderly.

In March, Secretary of Health and Human Services Dick Schweiker assured older Americans that he would protect the rights of nursing home residents, a uniquely vulnerable group. He stated, and I quote: "I will not imperil senior citizens by removing Federal protections. I will not turn back the clock."

Yet the changes proposed in inspection and certification of nursing homes threaten to do exactly that—turn back the clock to a time when the Government stood silently by as rights of the elderly were widely violated.

In an industry in which 80 percent of all homes are found to be in violation of the Federal health and safety standards, the implications of any regulatory reforms are severe, particularly at this time, because it could not come at a worse time, when resources made available by the Federal Government seem to be cut back at each turn.

Through the testimony presented today, I am hopeful we can obtain a clear view of the effects of these proposed changes. By listening to experts with diverse backgrounds and experiences, we can obtain a better picture of which reforms are truly needed and which must be avoided.

I understand the need to provide regulatory relief for responsible nursing homes and to use limited regulatory resources with maximum effect. But such reforms must be developed through careful consideration of the needs of nursing home residents, not through hasty efforts to achieve transient and false economies.

We owe senior citizens guarantees that if they need nursing home care it will be of high quality. We would be remiss in that duty if we accepted the current proposals as they stand without fully exploring the implications and their possible alternatives.

Let us proceed with these hearings with a commitment to determine that regulations can maximize the quality of service provided, while minimizing the burden imposed on responsible institutions. But above all, let us never forget we are dealing with issues affecting the lives and health of some 1.3 million human beings who depend upon us to protect them.

Thank you, Mr. Chairman. I look forward to listening to the testimony.

Mr. FLORIO. Thank you very much.

We have, as I indicated earlier, a very extensive list of witnesses today. For the benefit of all witnesses, any prepared remarks they have will be entered into the record in their entirety and they may feel free to proceed as they see fit.

We are very pleased to have as our first witness the commissioner of health from the State of New Jersey. We would ask her to come forward, the Honorable Dr. Shirley Mayer.

Welcome, Commissioner, to the committee.

STATEMENT OF SHIRLEY A. MAYER, M.D., MPH, COMMISSIONER OF HEALTH, STATE OF NEW JERSEY, ACCOMPANIED BY FREDERICK F. HEBELER, DIRECTOR, HEALTH FACILITIES INSPECTION SERVICES

Dr. MAYER. Thank you very much, Congressman Florio and Congressman Hughes, for inviting us to share our comments with you in this very important area.

I have with me today Mr. Frederick Hebeler, director of our health facilities inspection unit for the health department.

When I became commissioner of health in New Jersey a few months earlier, I announced my intention to make the health of the elderly a top priority. Certainly in New Jersey, as elsewhere in the Nation, the elderly are our fastest growing population group and we do know that at least 81 percent of the elderly display one or more chronic illnesses. Obviously, there is a very large group of people in this State and this country who have a true need for nursing home care.

I commend the Health Care Financing Administration for attempting to simplify the Federal regulations pertaining to medicare and medicaid coverage for nursing home patients. While the elderly comprise 10 percent of the population, they comprise 20 percent of the poor. With the number of elderly persons growing, it is essential that the Government insure that enough nursing homes are capable of serving this needy population and are certified to provide medicare and medicaid reimbursable services.

In analyzing the proposed regulations, we must first look at the roles and responsibilities of the State and Federal Governments in insuring compliance with nursing home standards.

On the Federal level, responsibilities include:

One, promulgating regulations to safeguard patient health and safety;

Two, providing funds to the States for nursing home inspections;

Three, backing up State inspection teams by providing a mechanism for the termination of Federal funds in noncompliant homes; and

Four, evaluating the thoroughness of State inspections from time to time.

Here in New Jersey, our responsibilities include:

One, monitoring the quality of health care services through periodic inspections;

Two, providing several teams of well-trained, professional surveyors to perform these comprehensive inspections; and

Three, recommending administrative action against noncompliant facilities.

The State and Federal funds which make these inspections possible are funds well spent. Any reduction in funding would reduce the number of qualified staff members who conduct these surveys, and would reduce the frequency of these inspections.

I am compelled to point out that eliminating the Federal funds that support State inspections, and requiring JCAH inspections instead, may not save the Federal Government much money in the long run. JCAH inspections must be paid for by the facilities, and this cost would be passed on to the residents in the form of higher rates.

Since the Federal Government pays these rates on behalf of many of the residents, it is difficult to see any savings accruing to the Government. Indeed, the higher fees could be more costly than the current practice of paying the States to do the medicare/medicaid certification inspections.

Furthermore, the JCAH inspections would be duplicative. When the State health department conducts its own inspection for licensure purposes, we can simultaneously conduct an inspection on behalf of the Federal Government for certification purposes. This allows for better use of staff time and less disruption for the nursing home.

I would like to point out at this time that we in the State health department are currently looking at a proposal to coordinate with the JCAH regarding hospital inspections. We are supportive of the concept of using an inspection team's time more efficiently and eliminating duplication of effort.

I respectfully suggest that prior to any final decision on these nursing home regulations, a pilot study be conducted to test their effectiveness and that other ways of coordinating with the JCAH be explored as we fulfill our responsibility of insuring the provision of quality health care to the elderly.

Returning to the subject at hand, I would like to touch on two final areas of concern:

One, how these proposals would affect the health and safety of nursing home residents; and

Two, the issue of public accountability.

Regarding patient health and safety, I believe that if nursing homes were allowed to be certified as eligible to receive medicaid or medicare funds for an unlimited period of time as proposed, valuable leverage would be lost. A time-limited agreement is needed so that the survey agency can compel a nursing home to correct deficiencies within a given time period. The ending date for the agreement also serves as a cutoff point for Federal funds for those facilities which refuse to meet minimal safety standards.

In addition, experience has shown that with very few exceptions, every nursing home should have some kind of inspection at least annually. If we are to guarantee nursing home residents quality care, there must be some stimulus, such as an inspection, for the staff of a facility to consistently strive for the kind of quality care outlined in the regulations. We are aware that these are often rapidly overturning staffs, and you have new people coming in who need new training. We believe annual inspections are one of the best ways to motivate a facililty's health care providers.

We also believe these inspections must be unannounced. Again, history has shown that announced inspections do not uncover deficiencies that unannounced inspections have revealed.

We see another problem with the proposal in that it does not include the current system which allows us to ban admissions at a noncompliant facility. Currently, when the State health department inspects a facility for licensure purposes, we can immediately bar the facility from admitting any additional patients the minute we see patient safety in jeopardy. This would not hold true with JCAH inspections.

Furthermore, not only does the State health department have the mechanism to inspect a facility and curtail admissions when conditions warrant, but we also are available around the clock, maintaining a 24-hour hotline for nursing home residents and their families who have complaints about patient care.

What I would like to stress is that local control is necessary in order to take immediate corrective action. This tack, I might add, is consistent with what has come to be known as the New Federalism. I am firmly convinced that what can be done locally, in this case, at the State level, is best done locally, as it will thus be more responsive to local needs and problems. National organizations, on the other hand, are less attuned to the needs of the local population.

The final question, as to how public accountability would be affected by the proposed changes, can be answered by making the following observations:

One, the JCAH is not required to make its inspection reports available to the public, whereas our State surveys are widely distributed;

Two, the JCAH does not have any enforcement powers to require corrections where deficiencies are found, nor does it investigate complaints as the State does;

Three, the JCAH is a private, independent agency not accountable to the taxpayers, as the State is; and

Four, the JCAH is not periodically checked by any other agency, as the State is, to insure that its inspectors are doing a thorough job.

In conclusion, I want to say that, fortunately, geriatrics is now a growing specialty, and recent interest in the chronic diseases of the elderly makes possible, for the first time, improvements in the quality of life even for nursing home residents. However, we still have a long way to go in changing society's attitude toward its senior citizens so they are treated with the care and respect they deserve. Dilution of present nursing home inspection practices, as outlined in the proposed regulations, is inconsistent with the leadership role demanded of State and Federal Governments to promote new knowledge in the nursing home field. The New Jersey State Health Department, therefore, urges that the implications of the regulatory changes be reconsidered.

Thank you again for the opportunity to speak, and if the committee has any questions, I and my staff are at your disposal. Thank you.

Mr. FLORIO. Thank you very much. We do appreciate your very succinct and very specific statement. It is very helpful.

I am particularly impressed with the suggestion that these regulations, if they are implemented, should be on a pilot project basis so as to perhaps test them on a much more limited scale than universally across the Nation.

I would at this point recognize Mr. Hughes.

Mr. HUGHES. Thank you.

Thank you for your very fine testimony.

As I understand it, Doctor, you do support the elimination of quarterly staffing reports as long as they would be available on an as-requested basis?

Dr. MAYER. Yes, we do.

Mr. HUGHES. Let me ask you: What is the situation in other States? Obviously, New Jersey has the capability without having them, the quarterly staffing reports, made available on a routine basis. What is the practice in other States, however?

Dr. MAYER. Perhaps Mr. Hebeler is more familiar with that than I am.

Mr. HEBELER. I do not know.

Mr. HUGHES. This would still require the nursing home to maintain staffing reports, however.

Mr. HEBELER. Yes.

Dr. MAYER. They would be available.

Mr. HUGHES. All it would be eliminating would be responsibility for forwarding them to the State?

Dr. MAYER. Yes.

Mr. HUGHES. Is that such a burden that we should worry about saving what, in essence, would be—what?—just a mailing in the State of New Jersey?

Dr. MAYER. I guess it is filling out the report.

Mr. HEBELER. The reports are available to us in the facility, and with the present survey practices, we have the right to review them and we do review them. The mere mailing of them in to us quarterly generates paper.

Mr. HUGHES. I see.

Mr. HEBELER. Which we do have to store. But it really doesn't generate knowledge or anything of that nature. We drop in in the middle of the night and we can check to see whether they have a nurse on duty. We drop in on weekends. We are not without resources of staff right now. We also, as you know, have an ombudsman group that does likewise in the State of New Jersey.

Mr. HUGHES. I have been led to believe that it has been some of the staffing reports that have alerted you to some of the problems in some of the nursing homes. If you do not visit the nursing home for an inspection, are we safe in assuming that, otherwise, any deficiencies in staffing would not be brought to your attention?

Mr. HEBELER. That works both ways. Some of the staffing reports are not altogether accurate. We find out in our surveys that it is kind of like if you were in the Army years ago, an M-1 pencil and a guy got a sharpshooter's badge.

Mr. HUGHES. In essence, you feel that that particular rule or regulation is not nearly as important in the State of New Jersey as some of the others that you have testified in opposition to, such as the annual reinspection and others that you feel are essential?

Mr. HEBELER. Given the survey capability we presently have, and if it can be maintained, we don't think that is a problem.

Mr. FLORIO. Would the gentleman yield?

Mr. HUGHES. I would be happy to yield.

Mr. FLORIO. Doesn't your argument fall a bit in light of the new funding cutbacks? Let's assume at this point that you feel the reports are not as essential as they could be. But if you are going to have less money and have less people out in the field going to facilities, doesn't that dictate a greater reliance upon mandated staffing submissions?

So hopefully, relying upon accurate information submitted to you, you go out and take a look. By wiping away the mandatory submission, you have even less ability to target your resources than you might under normal situations, and these are not normal situations where funding cutbacks occur.

Mr. HEBELER. Again, we question the credibility of some of the submissions. We are in a position where, if we are cut, they will definitely cut into the survey capability.

Mr. HUGHES. Well, additional cuts are coming.

Mr. HEBELER. If there are additional cuts, we may have to take a different position.

Mr. HUGHES. My colleague has picked up on just exactly what gives me concern; that is, we are going to have fewer resources and you are going to have less ability, I would think, to be able to identify those nursing homes that require an inspection, unannounced or otherwise.

Mr. HEBELER. We know right now who the facilities are that we have to watch the closest. After 7 years of surveillance of the facilities, we basically know who needs the most surveillance.

Mr. FLORIO. I just want to reinforce the point the Commissioner made in terms of appearing to save money and, in fact, ending up spending more money. I am speaking of, the accreditation process. I assume a portion of the rationale was that there can be some money saved by absolute reductions in the budget submissions under the existing accreditation process.

But as I point out, very accurately, the ultimate cost of the new accreditation process is going to be passed back to the recipients, and the recipients have most of their bills paid for by governmental programs, medicaid, medicare. This is just going to translate into higher governmental costs and in a less efficient way.

I think your point is well taken. Unfortunately, as Congressman Hughes and myself found out in a number of other areas, a shortsighted approach seems to be prevailing to a great extent in Washington. This is a process of cutting up front to deal with the immediate budgetary consideration, but doing it in such a way that you are going to probably end up paying more in the longer haul, and perhaps not even in the longer haul, in the intermediate range.

But I appreciate your participation today and thank you very much for your testimony.

Mr. HEBELER. Thank you.

Dr. MAYER. Thank you.

Mr. FLORIO. For our next witness, we are pleased to have the Director of the Office of Standards and Certification of the U.S. Health Care Financing Administration of HHS, Mr. Thomas Morford.

Mr. Morford, welcome to the committee. It is my understanding that you are accompanied by Mr. William Toby, Region II Administrator.

STATEMENT OF THOMAS G. MORFORD, DIRECTOR, OFFICE OF STANDARDS AND CERTIFICATION, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JAMES J. CONRAD, CHIEF, FINANCIAL AND ADMINISTRATIVE MANAGEMENT BRANCH, OFFICE OF STANDARDS AND CERTIFICATION; AND JAMES MORRIS, PRINCIPAL PROGRAM REPRESENTATIVE, BUREAU OF HEALTH STANDARDS AND QUALITY, REGION II, HEALTH CARE FINANCING ADMINISTRATION

Mr. MORFORD. Thank you, Mr. Chairman.

Mr. FLORIO. As I have indicated to our previous witnesses, Mr. Morford, your complete statement will be entered into the record.

Mr. MORFORD. Thank you, Mr. Chairman. I have submitted my formal comments for the record and will proceed to summarize.

Mr. Toby was unable to accompany me today, but with me is Mr. James Conrad, Chief of the Financial and Administrative Branch in my office. On my left is James Morris, who is the Health Standards and Quality Bureau principal regional program representative of region II in New York.

I appreciate the opportunity to be here addressing some of the concerns and confusion on the regulations.

Your committee has a strong and admirable tradition of protecting the health and safety of the Nation's elderly. I can assure you we share the same goals. We share assure your commitments that patients under medicare and medicaid receive high quality care. I believe our goals are consistent with these objectives.

I believe the proposed rules allow for two fundamental things: first, for increasing State options and, thus, the flexibility that

each State has to run the survey and certification process; and second, bringing about additional resources and more health involvement in the certification process.

Since 1973, the process of certification has not changed substantially. In 1980, the Health Care Financing Administration conducted hearings throughout the country at our 10 regional offices, as well as in Washington, D.C. We had considerable testimony. About 40 States testified at the various hearings, along with representatives of the health care industry, consumer advocacy groups, private individuals, and so forth.

Taking the results of those hearings, and conducting analyses over several years, we have come up with what is our best thinking on these current procedures which were published in the Federal Register, as you noted, on May 27 as a Notice of Proposed Rule Making (NPRM).

I would like to emphasize that this is a NPRM. While it represents, our best thinking to date, it is a NPRM. We are taking public comment, and I think one of the benefits of a hearing like this is that it enables us to get even more information from the public than is normally mailed in through the Federal Register process.

As you probably know, Dr. Davis and I were before the Senate Select Committee on Aging yesterday. You also mentioned that there are future hearings to be held over the next month.

Before I discuss the specifics of the regulation, let me just say two things: we have no intention to allow unsafe facilities to participate in medicare and medicaid, nor do we allow health care facilities to go without inspections on what we believe is an appropriate schedule.

Let me summarize the specific regulatory provisions and then I would be pleased to answer questions.

First, one of the provisions is the modification of the requirement to submit quarterly staffing reports. I would emphasize again that we are simply eliminating the mandatory requirement that all facilities must submit the staffing reports every quarter on a routine basis. We believe that in some cases this is essentially a paperwork requirement.

The State survey agency will maintain the option under this proposal to continue staffing reports every quarter it can do that. It can continue staffing reports for selected facilities, whether it be quarterly, weekly, or as frequently as it feels necessary to assure appropriate staffing is maintained at any particular facility.

Another proposal that we have is to eliminate the requirement for the mandatory resurvey of facilities within 90 days, where, despite the nature of the deficiency, the survey team must return within 90 days to do an onsite survey.

Again, the point is flexibility. We believe the State should have the right to go back to the facility depending upon the nature of the deficiency. If there is a structural problem with the facility, and the planned correction will take 6 months, it may be pointless for the State to resurvey in 90 days.

By the same token, depending upon the nature of the deficiency, the State may want to go in more frequently. We would certainly support those efforts.

Another regulatory proposal is modification, of mandatory annual surveys.

In the 1981 Ominibus Budget Reconciliation Act Congress eliminated the requirement in the Social Security Act that provided agreements with skilled nursing facilities not to exceed 12 months. I believe the legislative history of that particular act indicated that experience showed that facilities which were excellent need not necessarily be resurveyed on an annual basis.

We have, thus, a proposal we believe is an appropriate balance in terms of mandatory surveys; namely, hospitals must be surveyed at least every 3 years, all other facilities including nursing homes, at least every 2 years, and intermediate care facilities for the mentally retarded, at least on an annual basis.

I would stress that those are maximum time frames allowable. I am sure we will get into the issue of flexibility shortly, but the State could indeed go back more frequently. Indeed, in facilities that merit that kind of treatment, we would urge the State to do that. Resources, we think, should not be spent needlessly in some cases to go back to facilities with a very good record.

In conjunction with this, we think we have eliminated another paperwork requirement called the automatic cancellation clause. This requirement caused facilities—skilled nursing facilities or intermediate care facilities—to have the agreement immediately canceled if a certain deficiency was not corrected.

Program experience again indicates that this automatic cancellation clause has not been used over the last 3 years to terminate a facility. What we have discovered is, and our experience in one or two courts throughout the country indicates, that the paperwork burden of the automatic termination is needless because the State goes through a normal termination process.

So we believe that the requirement has become, in effect, obsolete based upon our program experience.

Finally, we have proposed that those facilities accredited by the JCAH, including skilled nursing facilities, intermediate care facilities, and hospital-based home health agencies, be given deemed status.

Again, I would stress, that there is a wide range of options for State governments in this proposal. State governments have the option in title XIX facilities or title XVIII and XIX facilities to grant this deemed status or not. It will be a State decision.

There is also another range of options, namely, the State could deem accreditation by the JCAH for certain aspects of the survey process and conduct only monitoring surveys, or continue the survey process for other programs.

Again, I think it emphasizes our move toward flexibility and allows a very highly respected health professional group to give its knowledge to health care facilities.

I would emphasize that we are eager to take comments, and alternative suggestions. I can fully assure you that they will be taken into consideration in the analysis for a final rule. The NPRM comment period, closes July 26. We are projecting at least 2 months of analysis after that time.

Again, it is a pleasure to be here. I would be very happy to answer any questions you might have.

[The prepared statement of Mr. Morford follows:]

PREPARED STATEMENT OF THOMAS MORFORD, DIRECTOR, OFFICE OF STANDARDS AND CERTIFICATION, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION

I am Thomas Morford, Director of the Office of Standards and Certification of the Health Standards and Quality Bureau of the Health Care Financing Administration. I am pleased to appear today to discuss the Department of Health and Human Services' recently proposed regulations which will improve the survey and certification process for health care facilities under Medicare and Medicaid. With me today are James Conrad, Chief, Financial and Administrative Management branch, Division of Field Operations, Health Standards and Quality Bureau, Baltimore, Maryland, and James Morris, Principal Program Representative, Survey and Certification Section, of the Regional Health Standards and Quality Division, New York City, New York.

Your committee has a strong tradition of interest in protecting the health and safety of our nation's elderly. We believe that our interests are compatible with yours.

Last year, the Congress recognized that the statutory basis for annual surveys of skilled nursing facilities was no longer necessary. The Congress in repealing the provision of the law that required annual surveys stated that "program experience indicates that many facilities have been consistently in compliance with the Medicare conditions of participation." We strongly supported that legislation, and believe that our regulations are consistent with this philosophy.

We are committed to assuring that patients under the Medicare and Medicaid programs receive high quality health care. Our proposed rules are consistent with this goal. First, they allow for an increased focus on our enforcement efforts on problem facilities. Second, through our deeming proposal, we will increase the involve current procedures for Medicare, the Federal Government contracts with State survey agencies which make recommendations to HCFA. HCFA makes the final determination on whether the provider qualifies for participation. In addition, hospitals that are accredited by the Joint Commission on Accreditation of Hospitals are deemed to meet Medicare's conditions of participation. Under Medicaid, the State determines whether a provider meets the health and safety requirements and makes the final certification decision. Most providers which qualify under Medicare automatically meet Federal eligibility requirements for Medicaid.

Since 1973, the survey and certification procedures have not been changed substantively. In 1980, HCFA conducted public hearings on the continued appropriateness of our procedures; hearings were held in each of our 10 regional offices, and here in Washington, D.C. Many witnesses were given the opportunity to testify and presented thoughtful suggestions. Upon reviewing these comments and our own analyses, we determined that some of our survey and certification regulations should be revised or modified. We concluded that, while the regulations were well intended and had served their original purpose, times have changed and they could be improved upon. We found them duplicative, cumbersome or an unnecessary burden on some providers. Most important, the current procedures are not essential to assure quality care to our beneficiaries.

We have found that provider performance varies widely, the current process does not recognize this variability. For example, why should a hospital with minor deficiencies be surveyed as frequently as one that has been shown to have major problems? Why should hospitals automatically be surveyed with the same frequency as home health agencies? We believe that the Government should concentrate more of its scarce resources on those providers whose past history demonstrates problems, and should not spend the same amount of resources on institutions whose record has been superior. Through our Medicare/Medicaid automated certification system (MMACS)—which contains general descriptive information on all participating nursing homes—we have the ability to identify good facilities and to track bad ones. Our beneficiaries are not necessarily protected by annual surveys of good facilities and beneficiaries in problem facilities are better served by those providers being subject to more attention. The proposed regulations will correct that imbalance, by focusing upon those providers that warrant closer and more frequent inspections.

In May, Secretary Schweiker announced the proposed survey and certification rules. When the Secretary decided earlier this year not to change the conditions of participation, he stated that we would strengthen the enforcement method of surveying providers. Before I discuss the specific provisions of these regulations, I would like to make clear what these proposals will not do:

They will not allow unsafe or deficient facilities to participate in Medicare and Medicaid; they will not allow any facility to go without inspections; they will not decrease the frequency of inspections of intermediate care facilities for the mentally retarded (ICF/MRs) and most importantly, they will not result in any less protection of Medicare or Medicaid beneficiaries' health and safety.

It is always critical that in all Federal activities, the optimum use of funds be our foremost goal. In these times of ever-increasing Federal budget deficits, it is imperative that every dollar be spent prudently.

Thus, in reviewing our survey and certification activities, we found it necessary to find the best way of accomplishing our responsibilities by targeting our limited resources toward those areas that need the greatest attention.

The Department is committed to a budget sufficient to support the survey process. In May, Secretary Schweiker requested approval from the Congress to reprogram $9 million within the Health Care Financing Administration's program management appropriation to be added to this year's Medicare survey budget. However the House and Senate Appropriations Committees did not approve this request. To enhance our efforts to inspect substandard facilities, we will be sending a supplemental request to the Congress to make an additional $4 million available.

I would now like to discuss each of the issues in our proposed regulations in some detail.

DEEMED STATUS FOR JCAH-ACCREDITED FACILITIES

The Joint Commission on Accreditation of Hospitals (JCAH) is a nationally respected accrediting organization. Its prestige was such that, when Medicare was enacted, the law provided that hospitals which were accredited by the JCAH were deemed to meet the conditions of participation for Medicare. The statute also allowed deemed status to be extended to other providers. Within that context, we are proposing to accept JCAH accreditation as sufficient evidence that skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and hospital-based home health agencies meet Medicare conditions of participation. Under this proposal States could, at their option, accept JCAH accreditation for Medicaid or those facilities that participate both in Medicare and Medicaid. This will permit States to determine the survey method that they believe will work most efficiently for providers receiving payment under Medicaid.

In considering whether to extend deeming, we took a long, hard look at the JCAH's survey procedures and standards and surveyor qualifications. We determined that the JCAH process and standards are equivalent to and in some areas superior to our own. For example, some of the JCAH requirements for disaster preparedness are stricter than Medicare's. The JCAH record in the Hospital sector is excellent. We have no reason to believe that the JCAH would perform any less effectively in assuring health and safety standards in other providers. Additionally, about 1300 SNFs and ICFs currently approved for Medicare and/or Medicaid are accredited by the JCAH.

The deeming provisions eliminate existing duplication of survey effort which now can involve several agencies. In your letter to us, Mr. Chairman, you asked about the effects of this proposal on the cost of the survey and certification program.

We expect that there will be no additional Federal costs. While the Federal government pays a share of accreditation costs as allowable costs under Medicare, we also pay the cost for the surveys conducted by the State survey agency. These costs should offset one another. In fact, our cost may decrease, since some facilities are not surveyed both for accreditation and certification. However, our proposal was designed to improve the survey process, not to save money.

To further protect Medicare and Medicaid beneficiaries, we included the following additional requirements:

As a condition of deemed status, the facility must post its current JCAH report of the survey findings in a prominent place so the public may examine it. This differs from current procedures whereby JCAH finds are confidential.

HCFA may revoke deemed status of JCAH-accredited facilities if it determines that accreditation no longer provides reasonable assurance that facilities meet Federal Requirements. In addition, regular validation surveys would be conducted on accredited long-term care facilities on a selective sample basis or in response to allegations of significant deficiencies.

Any provider accredited by the JCAH would have to meet any higher health and safety standards that may be prescribed by HCFA.

FLEXIBLE SURVEY CYCLE

At present the State agencies are required to survey all medicare or Medicaid providers at least annually, regardless of their compliance history. The Congress has indicated, and we believe, that annual surveys are a needless burden on facilities whose compliance record is excellent and on states which may not be able to devote staff to such frequent surveys.

For these reasons, we are proposing elimination of mandatory annual surveys for most providers. Under our proposed regulation, hospitals would be surveyed at least once every 3 years. All other facilities would be surveyed at least every 2 years, except for intermediate care facilities for the mentally retarded (ICFs/MR) which would be surveyed at least annually. In this regard, I would like to make two important points:

1. These are the maximum length of time between inspections. If a nursing home, for example, had a poor record of compliance our regulations would allow more frequent inspections.

2. ICFs/MR present a special case—most of these patients are not able to bring problems of quality of care to the attention of outside authorities. Thus, we propose that ICFs/MRs be surveyed each year to make certain that serious problems are detected and solved.

Our Office of Research and Demonstrations is funding experiments in 3 States designed to make the nursing home survey and certification process more effective. Preliminary results from an experiment in Wisconsin, suggest that the experimental methods did result in a reallocation of surveyor time toward problem homes.

TIME-LIMITED AGREEMENTS

As I pointed out earlier, last year the Congress repealed a provision which had been in effect since 1973 requiring that skilled nursing facility provider agreements under Medicare be renewed on an annual basis. This change in the law was made because there was nothing particularly useful in a uniform annual requirement. Our proposed regulations would eliminate 12-month agreement for Medicaid SNFs and ICFs. This will reduce unneeded paperwork and recordkeeping requirements, and will permit monitoring of marginal facilities more often than once a year, and others less often.

QUARTERLY STAFFING REPORTS

Currently the State survey agency is required to obtain from each facility a report showing the number of full-time employees. The report is due once each quarter and covers 1 week selected at random by the State agency during the quarter. The survey agency is required to evaluate the report and take appropriate action when the reports indicate inadequate staffing is indicated. Although this process was established to enable the State to monitor throughout a year a facility's compliance with staffing requirements, this process takes considerable time and effort with no noticeable benefit. We therefore are proposing modification of the current policy to require the staffing reports only where a facility has been shown to have deficiencies in staffing during its most recent certification survey or is marginal in meeting staffing requirements. However, all facilities will be required to have the information available when they are surveyed. This change will allow the surveyors to monitor compliance with staffing requirements in a less burdensome, more targeted fashion. As with other provisions, I would like to emphasize that States may obtain such staffing reports at other times if they wish to do so.

90-DAY RESURVEY

At present, if deficiencies are found on annual surveys, the State is required to conduct a follow-up visit to the facility within 90 days to verify that corrective action is completed or progressing at a reasonable rate. We have found, however, that the 90-day requirement does not allow for realistic and practical timeframes for follow-up. For example, if it is agreed that a deficiency would take 4 months to correct, a 90 day follow-up is virtually a waste of time. The 90-day requirement is arbitrary and should be eliminated. However, we do not want to eliminate the requirement for follow-up by the survey agency. So, our proposed rules specify that the survey agency would be required to follow-up on a deficiency at a time when progress or correction can be assessed most realistically. We also would permit telephone or mail contact, when appropriate to follow-up on or verify the correction of certain deficiencies where on-site visits are not needed. For example, if the minutes of a

governing body were missing, these could be mailed to us, rather than requiring a visit to the facility to obtain them.

CERTIFICATION CANCELLATION CLAUSE

Currently, a SNF or ICF which is not in full compliance with all standards may be certified and approved subject to an automatic cancellation clause, (i.e., the agreement will expire not more than 60 days after the latest date established for the correction of deficiencies unless the corrections have been made). This policy was established because some facilities were cited for the same deficiency year after year. However, all deficiencies were given equal significance: Thus, any deficiency regardless of its nature could serve as the basis for cancellation of agreements. This lack of differentiation between deficiencies could result in many nursing homes being automatically cancelled for minor problems—over 90 percent of these cancellations eventually are rescinded after a time-consuming and burdensome process. We believe, therefore, that it is better to eliminate the automatic cancellation requirement and concentrate upon those facilities that have major deficiencies. Other sanctions would be applied to such facilities, such as denial of reimbursement for future medicare-medicaid patients or, if necessary, termination.

I would like to strongly re-emphasize that our proposed regulations would not permit any facility with life-threatening deficiencies to continue to participate in our programs. The termination of facilities with life-threatening deficiencies is in no way affected by our proposals. We will not permit beneficiaries to have their health and safety jeopardized.

In conclusion, our proposed regulations are designed to eliminate cumbersome and unnecessary requirements and to concentrate our scarce resources on providers with deficiencies. Our regulations are open for comment and we welcome your suggestions, as well as those of beneficiaries, consumer organizations, States and providers. We look forward to receiving comments and will carefully consider them in the development of final regulations. We must all work together to ensure a safe environment for our medicare and medicaid beneficiaries, and this is our highest priority.

I will be happy to answer any questions that you may have.

Mr. FLORIO. Thank you, Mr. Morford. We do appreciate your testimony.

The key word that kept coming through was "flexibility," which was a very positive word in the sense that everyone is in favor of more flexibility, the assumption being, of course, we will target resources and devote effort to those areas where there is a need for attention.

Are you at all apprehensive, though, about the fact of flexibility coming at the same time as a greater limitation on resources? If we are going to provide the States more flexibility for enforcement, but the resources are going to be reduced, are you therefore not providing flexibility?

You may well be providing less capability to deal with the problems that perhaps are even more serious. Likewise, with regard to giving more discretion to the institutions to be self-regulators, we are, in these regulations, it seems to me, taking away some of the leverage that would induce those institutions to be self-regulatory.

Is that what you point out with the fact of the automatic cancellation provision not being used as evidence of the fact maybe it should be eliminated?

I can conceive of an argument on the opposite side. The fact that it is not used means that it is working, the penalty, the threat of automatic cancellation is inducing institutions to comply with existing regulations. If you take away that threat, there is no motivation, no leverage to be used in inducing some self-regulation and discretionary authority on the part of the State.

Are you at all apprehensive about that opposite side of the argument?

Mr. MORFORD. Let me address those two questions, Mr. Chairman, in order.

First of all, the question of resources is one we are all concerned about. Secretary Schweiker has, I would say, demonstrated his commitment to nursing home regulation in that he requested earlier this year a reprogramming of $9 million in Health Care Financing Administration accounts to expand the nursing home inspection program.

The Secretary forwarded that request a couple of months ago to the House and Senate Appropriations Committees, however, that request was turned down. He has further indicated recently that this is not a budgetary issue. The Administration is discussing, in fact, supplemental funds not only for the remainder of fiscal year 1982 but for fiscal year 1983, so that this program can be fully supported in concert with the Secretary's decisions.

So on the contrary, resources will not be cut back. The President's 1983 budget calls for more resources. And again, the Secretary is considering requesting even more funds than that.

Mr. FLORIO. Mr. Morford, you are aware of the fact that $5 billion is sought in reductions in the administration's budget for fiscal year 1983 in the medicare/medicaid field. Regardless of where the specific allocations are going to be reduced, some component of the total program is going to have to feel a cut when you start talking about reductions of that magnitude.

When you then say to the States you have the discretion as to where you are going to use the resources, given $5 billion in cuts, there is some question as to where the State is going to put the priorities.

So I don't think it is fair to say there aren't any cuts contemplated.

Mr. MORFORD. I didn't say there were no cuts contemplated. I am, in fact, not an expert in the whole medicare/medicaid budget.

Mr. FLORIO. Our responsibilities, of course, are broader. Therefore, we have to be apprehensive about the worst-case scenario. You can say, "Well, the moneys are there for your particular department," but the big program, the medicare/medicaid program, will undoubtedly experience substantial cuts. It may be that as we provide the States more discretion, your judgment may not be followed that those moneys should be devoted to this particular program.

Mr. MORFORD. The medicare/medicaid budget process and expenditure of funds for particular services is a very complicated business. My expertise is fairly narrow in terms of this program. I can assure you, however, that there will not be a reduction of funds for the inspection program for either medicare or medicaid facilities.

I say this with the full assurance of Secretary Schweiker, who not only has made verbal commitments but has shown it in the request for $9 million more in terms of reprograming and for an increase in the President's fiscal year 1983 budget for this program.

I realize the other issues on medicare and medicaid will be taken up by your committee and other committees. But in terms of this very narrow program, that is the Administration's position.

In terms of automatic cancellation clauses and your question concerning my apprehension over this particular requirement being deleted I really am not concerned. I have the utmost confidence in our State agencies surveyors, such that if they find a deficiency that needs correction within a specified time frame, they will take the appropriate action.

I don't believe the automatic cancellation clause is necessary. I think State agencies will take appropriate action to move to correct the deficiency or take other sanctions they have under their authority.

Mr. FLORIO. Congressman Hughes?

Mr. HUGHES. Thank you, Mr. Chairman.

I want to echo the concerns of my colleagues. Yesterday you may have read the Ways and Means Committee vote to achieve roughly $11 billion in savings in the next 3 years from just this area, medicare and medicaid. But it is targeting areas to achieve savings through a whole host of measures, including passing on some of the costs of a hospital in changing some of the reimbursement features.

I understand what you are saying about the assurances of the Secretary in this area, but it is going to be very difficult to achieve. Roughly one-half of the tax increases are going to come from this area. We have to find $20 billion in order to comply with the fiscal year 1983 budget. Half of those savings are going to come in this area that we are talking about.

So I have some major concerns. You heard, I am sure, Dr. Mayer's testimony.

Mr. MORFORD. Yes, sir, I did.

Mr. HUGHES. One of the points she made, I think, bears closer scrutiny. She suggests that any effort to grant deemed status to nursing homes will end up costing more dollars, not less dollars.

What response do you have to that? She contends, and obviously they have had a great deal of experience in this whole era of deemed status, that is is going to require duplicative services anyway.

Mr. MORFORD. The fact that we would allow deemed status with accreditation means that for 98 percent of the facilities, it would be a State option. The cost to the Federal Government is balanced by the increase in expertise that the JCAH would bring to the area.

Also in terms of the Secretary's commitment to the budget, we will not reduce any State budgets in terms of their inspection budgets if they opt for the deeming provision.

Again, I am not an expert in terms of how these costs are negotiated, but any facility in the country, whether it be a hospital or a skilled nursing facility, has the option to seek JCAH accreditation. The JCAH can give deemed status to hospitals, but not yet nursing homes.

These costs are negotiated in terms of the facilities overhead rate and are picked up to some extent by medicare and medicaid. We can submit it for the record in terms of the medicare and medicaid overhead cost negotiations.

[The following material was subsequently received from Mr. Marford:]

The amount of overhead reimbursement provided by medicare and medicaid to the hospital for the cost of JCAH inspection is based on the relative usage of costs incurred between medicare, medicaid, and private sector beneficiaries. For example, if average usage of hospital costs incurred by medicare beneficiaries is 20 percent, then 20 percent of the JCAH accreditation fee charged to the hospital's administrative and general cost center would be attributable to medicare.

Hospitals with long term care beds prorate the fee of the JCAH inspection among total medicare, medicaid, and private sector costs. Therefore, deeming of those long term care beds would alleviate costs now being paid to the state agency for performing a distinct long term care survey.

Mr. HUGHES. Do you have data you can supply to this committee that would suggest that some savings are going to be achieved by granting this status as flexibility?

Mr. MORFORD. I don't really think it is savings, sir. I think it is a matter of providing the States more resources because we will not cut the inspection budget and the States can get the medicare/medicaid facilities accredited by JCAH.

So the State, it seems to me, is given a fairly decent option, because it can have the facility accredited by the JCAH, and thus, deemed for medicare and medicaid, and yet have a wide range of options open to it in terms of how to monitor the JCAH accreditation through validation, monitoring, and surveying programs.

So we are not proposing these regulatory changes to effect savings and budget cuts.

Mr. HUGHES. In effect, are you suggesting it is going to require less paperwork, less regulation?

Mr. MORFORD. Depending on how the State implements it, I think it would require less paperwork. I think in those facilities that are jointly certified and accredited we could eliminate one survey.

I would point to the area of hospital licensure, certification and accreditation, where over 30 States have already accepted JCAH accreditation in lieu of their own licensure requirements. The States feel that they are of that good a quality. These kinds of options would be open to the State.

In the area of hospitals, we have considerably reduced paperwork because we don't have multiple survey teams going in. Within those 30 States accepting JCAH acreditation, the facilities would be accepted, are accredited for medicare/medicaid and acceptable for State licensure.

Mr. HUGHES. Dr. Mayer suggested, if I understood her testimony correctly, that it wouldn't really save any paperwork. It would still require inspection by the State

Mr. MORFORD. Well, again, there are broad numbers of options open to States. Dr. Mayer is absolutely correct. The State could decide not to deem. The State could decide to conduct a more stringent program which would require more paperwork.

Mr. HUGHES. Let me move on to another question.

On quarterly staffing requirements, it is my understanding from your testimony—I listened to that aspect of your testimony—that if a State would require quarterly staffing information, they could request that without deemed status.

Mr. MORFORD. That is correct. Any time. It could be more frequently than quarterly.

Mr. HUGHES. It would not be targeted on just those nursing homes with a poor track record, but any nursing home?

Mr. MORFORD. They have that authority.

In terms of a State's regulation of nursing homes, if it finds a facility that has not had a staffing problem, say, over the last 3 to 5 years, it may not want to look at the quarterly staffing reports.

I think in some States with a large population of nursing homes, it does represent considerably extra paper that, frankly, isn't looked at. They nevertheless have the option.

Mr. HUGHES. I have just one further question, just to follow up on my colleague's concern about the automatic cancellation provision.

Do you have any data tht suggests that that provision has, in effect, as my colleague has indicated, provided the leverage that would insure that nursing homes comply?

Mr. MORFORD. The data we have, sir, is that it has not been used over the last 3 years.

Mr. HUGHES. See, that doesn't mean a thing.

Mr. MORFORD. I understand.

Furthermore, we have also indicated where a deficiency exists, and the State did want to move to termination, it has used the normal termination process. In fact, in a court—and I would, again, have to check for the record—but I believe it was a Federal district court, where one State tried to automatically cancel a provider's participation, and the court forced it to go back through the decertification process in order that it could prove the deficiency still existed.

Mr. HUGHES. Was that a lower court decision?

Mr. MORFORD. I believe it was.

Mr. HUGHES. We are not making policy by what some Federal district court does.

Mr. MORFORD. We are not. We are trying to improve the certification process and flexibility.

State agencies are responsible enough that when they see these deficiencies existing and see that they are not corrected, they will indeed move against those facilities without the automatic cancellation clause. According to our regulations, the automatic cancellation clause ought to be put into effect no matter what the magnitude of the deficiency, but it requires considerable paperwork.

Mr. HUGHES. I am not as concerned about the automatic cancellation provision—I have some concern about that—as I am with the annual survey requirement which I also believe has a certain amount of leverage. I would express my same concerns about that provision.

I think it does serve notice to institutions that they are going to be surveyed annually. Those surveys have picked up a lot of defects and problems in nursing homes. I would express my concern about that particular area of regulation also.

Thank you, Mr. Chairman.

Mr. FLORIO. Thank you very much.

Let me just conclude with some specifics to reinforce my apprehension about the concept of flexibility, and its end result.

It has been brought to my attention that in the last 2 fiscal years, Federal funding for New Jersey for nursing home surveys and certification programs has been reduced, as I have indicated previously, by 52 percent; that is, from $690,000 in 1980 to $332,000 in 1982.

This has resulted in the loss of 10 New Jersey Department of Health inspection positions, 3 fire safety and building inspectors, 3 health care evaluators, and 2 clerical positions. Two positions have been left vacant, reducing the office force from 70 to 58.

Now we are looking at fiscal year 1983 reductions that may result from the budget that we are considering at this point. Notwithstanding your optimistic assurances, I just don't know how we are going to be able to make more out of less when we are talking about cutbacks in some of these programs of the magnitude that we are.

Certainly the committee is aware of what the motivation is behind these regulations. We are concerned about what the actual impact will be, and that discretion is converted into mandatory lowering of standards if, when you grant the discretion, the resources dictate which option you take.

One of the options may be the less costly, but it may not be the one that is the most caring and most protective. Therefore, the State's flexibility is reduced because there really is only one option, and that is the lesser amount of allocation of resources because those are the only resources that are available.

So we are going to take a look very closely, as you know, at the impact of these regulations at the full committee level. We appreciate your participation here today and would ask you to communicate that to the Secretary, as well.

Mr. MORFORD. Thank you, Mr. Chairman. It has been my pleasure.

Mr. FLORIO. Thank you.

Our next witness is Mr. Jack Fay, New Jersey Office ombudsman for the institutionalized elderly, accompanied by Stuart Weiss, executive director.

STATEMENT OF JOHN J. FAY, JR., NEW JERSEY OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY, ACCOMPANIED BY STUART WEISS, EXECUTIVE DIRECTOR

Mr. FAY. Congressman, I was supposed to be in Washington testifying to your full committee on SSI. Congressman Pepper had to cancel. Therefore, I could be here in person today to give our office's statement.

Mr. FLORIO. We are very pleased.

Mr. FAY. I want to start off by thanking you and Congressman Hughes and the full committee, remembering the last time I testified to you was after the horrible fires in boarding homes. I am pleased to say there have been some definite movements on the part of the Federal Government into fire safety standards and also the fact that Congressman Pepper and the full committee is holding hearings on this issue.

On the changes in the rules and regulations, I have already sent my feelings off directly to Secretary Schweiker in the Department

of Health and Human Services. I feel that the Secretary is being very poorly served in these proposed recommendations.

The standards for nursing homes right now in New Jersey and the rest of the Union are minimal, to begin with. Anyone who has been close to the subject, to the field, to the people, knows what we have gone through for the last 8 or 9 years.

The scandals in New York and in every other State of the Union, including New Jersey, brought us up to, both on a State level and on a Federal level, to minimal standards. In my State, and to the Secretary and to this committee, I am insisting that the idea that the good homes do not need a mandatory yearly inspection is not facing reality because the facts of the matter are that an excellent home, a very good home, can become mediocre or can become a poor home in a matter of 1 year.

A change of ownership, a change of administration, a change of the nursing staff, and suddenly this nursing home that you have known to be a very good one and an excellent one, this kind of change or changes can drastically affect it. It has affected nursing homes in New Jersey. The homes that do have fair or poor averages obviously need even more than one.

So this idea of playing with numbers or playing with, "Well, you don't need any. We will call you up every other year to find out if everything is still fine," is just not the proper way to inspect long-term health care facilities.

The next requirement of eliminating the resurvey of deficiencies, the 90-day deficiency, is again literally playing with people's health, welfare, and lives. The facts of the matter again are that 90 days is sometimes much too long to even wait. We are dealing now, immediately.

If we are talking about physical abuse, mental abuse, if we are talking about something which is more likely to happen, the kitchen has broken down, the food is being served cold and late for a second, fourth, sixth day, these are not the kinds of things that you even should wait 90 days for.

So the idea of dropping this completely is beyond my comprehension, how one arrives at this kind of a recommendation. Obviously, no one who has dealt with long-term care facilities for any length of time.

The problem of understaffing, which the commissioner of health and the gentleman from the Federal Government, I happen to respectfully disagree with both of them. I think understaffing is not only a present problem; it is a growing problem. You are going to hear later from representatives of the State Nursing Association.

This is a growing problem not just for nursing homes, but for every type of health care facility. Most people don't recognize or realize, either, that a nursing home, skilled nursing care or intermediate nursing care, they are not mini-hospitals. The facts of the matter are, again, that a nurse, an R.N., an L.P.N in a nursing home, is usually an administrator, is usually a supervisor.

The great amount of laying on of hands, the person who gets you up out of bed in the morning, takes you to the bathroom, helps you to eat, puts you back in bed, puts you in the wheelchair, walks with you, 75 to 80 percent of that laying on of hands is done by

nurses' aides; not a nurse, not an R.N., not an L.P.N., but nurses' aides.

Nurses' aides do most of this in nursing homes. In most States of the Union, little or no training for a nurses' aide. New Jersey is one of the few States of the Union. A little over a year ago the State department of health and State department of education started a mandatory minimal training program for nurses' aides.

Just last week in Morris County we investigated a complaint of understaffing. We found in 1 week's time they were shy 217 hours of R.N.-L.P.N. time and they were shy 711 hours of nurses' aide time. This is in an average, not bad by any means, nursing home in Morris County.

But yet these are the facts of the matter. Almost immediately, if you go through this kind of understaffing for any length of time, 2, 3 weeks, running into months, immediately you are going to be dealing with improper care.

I don't feel qualified enough to speak to their economic presentments here, just how much money is going to be saved over the long run, but I do know when we are talking about long-term care or talking about nursing homes and State and county institutions and residential boarding homes, we are talking about a level of a population, one that, by the way, happens to be growing.

You are dealing with the very old, very frail, very sick, in nursing homes, and we are dealing with medicaid people, very poor people. I would not want to be the one responsible for conjecturing this as an assumption that we are going to save money.

I strongly believe care is going to be affected, and it is going to be affected directly. I wouldn't want to be the one who, when we are dealing with overregulation, I cannot believe that this is an area where one should begin.

I think that the Secretary would be well advised, and I believe the Congress, what your committee can do to the rest of the Congressmen who are not that aware, who are not that knowing of this group of people that we are talking about, that this really, too, can serve a major public service by not only informing the Secretary but also informing your fellow Congressmen and Congresswomen.

That is my statement, Mr. Chairman.

[The prepared statement of Mr. Fay follows:]

PREPARED STATEMENT OF JOHN J. FAY, JR., NEW JERSEY OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY

I would like to thank Congressman Florio and Congressman Hughes for allowing my office to testify on our mutual concerns to themselves and the House Select Committee on Aging.

As one who has dealt directly with problems of the frail and sick elderly in our nursing homes and boarding homes for the last eight (8) years, I have appealed to Secretary Schweiker and I am appealing to Congress to rescind most of the proposed rules and regulation changes that govern nursing homes (both skilled nursing facilities and intermediate care facilities).

It is my strong feeling that Secretary Schweiker and the Department of Health and Human Services are being poorly served in these proposed recommendations. Standards for nursing homes, as they are now structured, are truly minimal. The history of tragic and horrendous incidents in the nursing homes in New York, and in every other State of the Union, have brought about these minimal standards. It would be a regressive step backward and a major retreat, to come such a long way in the past nine (9) years, to destroy these minimal safeguards that affect the defenseless and dependent men and women in our nursing and board and care homes.

The notion that the so-called good nursing homes do not need a mandatory yearly inspection is not facing reality. We have found, in several instances, that the excellent nursing homes can go down hill very quickly. Reasons usually are due to a change of ownership or change of administration, and/or change of nursing staff. It is vitally important and basic that these inspections take place at least once a year. Those nursing homes with problems need anywhere from two (2) to five (5) visits a year.

The thought of eliminating the requirement for resurvey of facilities with deficiencies ninety (90) days after the initial survey is literally playing with people's lives and welfare. The facts of the matter are, that ninety (90) days is much too long to wait for a reinspection of a facility, especially when the deficiency is in the area of diet, fire safety or under staffing; adult abuse and improper care calls not only for immediate response and then close monitoring.

As of late, the problem of under staffing has grown to be a most severe problem. The proposed new regulation limiting the requirement of quarterly staffing reports to those facilities with a history of staffing deficiencies is, once again, inviting nursing homes to cut down on licensed and unlicensed personnel hours which leads immediately to improper care. The constant check which hangs over the heads of nursing homes, administrators, forces them closer to compliance. Without that sense of monitoring, this is a very real situation where lives can be endangered.

It is most important to point out that RN's or LPN's are usually supervisors, with most of the laying on of hands by nurses aides, who have little or no training. New Jersey through the State Department of Health and State Department of Education is one of the few states in the Union that has just begun a "mandatory" nurses aide program.

These are issues that transcend party lines. It most certainly should not be in the direct care and protection of these vulnerable, frail, and sick people in the Long Term Care facilities in our Nation.

Mr. FLORIO. Thank you very much. You point out in a very succinct way one of the apprehensions we have as to the total medicare/medicaid budget cuts that are occurring. As the reimbursement payments to the institutions are reduced, many of them will be looking for ways of cutting corners so as to maximize their resources. So we are creating the conditions to induce staffing reductions and reduction of levels of care at the same time we are reducing the capability to ascertain whether those levels that are required are being met.

We are dictating circumstances that will require reduced staffing and reduced reporting requirements, and then reducing funding for the inspectors to go out and find out whether staffing levels are being maintained.

You have pointed out in very clear ways the deficiencies in the proposals and the apprehensions that I think we both have.

Congressman Hughes?

Mr. HUGHES. Thank you. I have no questions.

I just want to thank you for very incisive and helpful testimony.

Mr. FAY. Thank you.

Mr. HUGHES. Appreciate it.

Mr. FLORIO. One point coming out of the boarding home hearings we had about a year ago offers a good example. As you may recall we observed we have a very good law in New Jersey for the boarding home inspections. But in fact the law was not being enforced because we didn't have the inspection capability.

Mr. FAY. Yes.

Mr. FLORIO. Out of that hearing we also ascertained that many of the localities have building inspectors, fire inspectors who were able to go out and do the inspections, but they had no authority under State law.

It is my understanding that out of that hearing there evolved the effort to enter into contracts so that local people were able to perform the responsibilities of the State law and that a number of municipalities entered into such agreements.

Unfortunately now we find the States' resources generally being reduced so as not to be able to go forward with that contracting initiative. So we are finding resources being cut everywhere.

That would essentially preclude us doing that type of a joint State-local undertaking in this regard.

Mr. FAY. Congressman, this is why I don't believe—I am trying not to be parochial when I do report on the matter of nursing homes and the matters of boarding homes.

New Jersey is one of 11 States in the Union that has such a structure. Yet we are dealing with the social security law and social security money in 50 States.

New Jersey does have a strong department of health here and a strong ombudsman office, if I may say so. That is not true of many States in the Union. So we can say from firsthand knowledge about New Jersey, I do believe that this is a matter of the Nation's elderly and the Nation's elderly in long-term care, and not in long-term care.

In New Jersey 3,000 medicaid people are still waiting for nursing home beds.

Mr. HUGHES. Will the gentleman yield?

Mr. FLORIO. Certainly.

Mr. HUGHES. I have a copy of your letter to Dick Schweicker, Secretary of HHS. I realize that you are concerned about all the proposed changes. But if I read your letter correctly you are most concerned about 90-day reinspection. Am I correct?

Mr. FAY. Yes. The 90-day reinspection I think is the most serious.

Mr. HUGHES. I think that probably is the most critical of the proposals?

Mr. FAY. Yearly inspection I believe is minimal.

Mr. HUGHES. Thank you.

Mr. FLORIO. Thank you very much.

Mr. FAY. Thank you.

Mr. FLORIO. We will now have our first panel of witnesses. I would call to the testimony table Betty Rice, Camden County nursing home ombudsman; Jacqueline Vogelmann, director of nursing, Home Advocacy Center of Essex County; and Margaret Luck, community service outreach officer, Camden County Health Services Center.

Welcome on our committee.

We assure you your statements will be placed in the record in their entirety and request you go forward in a summary fashion.

Mrs. Rice, perhaps it would be appropriate for you to go forward.

STATEMENTS OF BETTY RICE, CAMDEN COUNTY NURSING HOME OMBUDSMAN; JACQUELINE VOGELMANN, DIRECTOR, NURSING HOME ADVOCACY CENTER OF ESSEX COUNTY; MARGARET LUCK, COMMUNITY SERVICE OUTREACH OFFICER, CAMDEN COUNTY HEALTH SERVICES CENTER

Mrs. RICE. Thank you, Congressman.

The Camden County Office on Aging is opposed to the proposed changes of HHS in nursing home regulations. We feel that quality care for residents is a must. Tampering with regulations which benefit the lives and sometimes the remaining years of human beings requires much care.

Providers of care must be reminded that they are dealing with people's lives and that their facility is not just a warehouse. For these reasons, I, therefore, submit the following:

1. ANNUAL INSPECTION

Annual inspection of facilities is a priority. It has been my experience that people or adminstrators strive to improve health and safety standards if regulations are stated and mandated.

Federal and State governments have the obligation to inspect our facilities on a regular basis.

2. STAFFING REPORTS

Quarterly staffing reports are necessary to insure the well-being of nursing home residents. If reports are not submitted, many homes will be lacking adequate health and consequently the residents will suffer.

3. ONSITE REINSPECTION

Without the mandatory 90-day reinspection it is doubtful that the rectification of the deficiencies would occur. Administrators need to know that they will possibly lose certification if deficiencies are not corrected within a certain given period of time.

FINALLY THE JOINT COMMISSION ON ACCREDITATION ON HOSPITALS VERSUS STATE INSPECTION

Because the State agency represents all the people we feel it should and will, in most instances, act in the best interest of the people.

I realize this testimony is brief. I do think the points made here are clear and hopefully emphatic. The message put simply and concisely is this: don't regulate the nursing home industry in this Nation merely for reasons of economics because the health, safety, and general well-being of the people, human beings, is of paramount importance and must be preserved.

Mr. FLORIO. Thank you very much.

STATEMENT OF JACQUELINE VOGELMANN

Ms. VOGELMANN. Thank you.

I would like to preface my statement by saying that yesterday I received some figures from the State board of health that indicate that these new proposed regulations would affect 28,405 patients in the nursing homes in New Jersey. So we are talking about a population of approximately 30,000 people.

As the director of the Nursing Home Advocacy Center of Essex County I work on a direct basis with issues around nursing home placement in that area. My work involves visiting the nursing homes, placement of residents into those homes, following up inves-

tigations and complaints in the nursing homes, working with the families of nursing home residents and working with the residents themselves. I also work with volunteers who go into the homes and we work with information and support groups for families of these residents.

I feel that I have a very realistic awareness of the positive aspects and the problem areas of nursing homes in Essex County. I also feel very strongly that many of the changes that have been proposed in the Federal Register would not be in the best interests of nursing home residents and might well be very detrimental to them. These residents are a frail, vulnerable population and they need all the protection that government can give them.

The current regulations provide that nursing homes are reviewed once a year. The new regulations call for more flexible surveys which would allow surveys to be done as infrequently as every 2 years. In the year that I have been a nursing home advocate for Essex County I have seen homes that were very highly recommended begin to slip and become shabby. Carpeting becomes torn, walls start to peel, food trays go back untouched, unpleasant odors appear, or the staff simply does not respond with the same caring attitude that they had done previously. These changes can occur very quickly if there is a change in administration or change in key staff personnel.

The director of nursing, for example, can set the tone for the attitude of the entire nursing staff. The average nursing home resident stays in the home for 2 years. It would be possible for a resident to live in a home and never have access to an inspection.

In addition to changes that can occur in the nursing facilities, resident conditions can change very quickly and go undetected between surveys.

The nursing home population has become sicker and more vulnerable over the past years. Advances in the medical field, home health care, day-care services, and the rising costs of nursing home care have all combined to postpone nursing home placement.

By the time a frail, elderly person enters a nursing facility he is less able to speak for himself. He often has no one to speak for him because he has outlived his friends and relatives. The residents, if anything, are more vulnerable to harm and poor treatment and need more than ever the protection that the State and Federal Government must provide.

Due to funding cuts many facilities have to cut back on their services. I am afraid government is going to send us back into the dark ages of the nursing home industry a few years ago, when elderly people felt—and some still feel—that they would rather die than to enter a home.

It is my personal experience that many people still feel that way. I spend a great deal of my time reassuring those that I speak to that going into a nursing home does not have to mean the end of a dignified, fulfilling existence.

I am afraid that if the survey and enforcement procedures are weakened in any way I may not be able to give this reassurance in good conscience.

In the same area the proposals will remove the requirement of a 90-day resurvey when a provider is out of compliance.

The present standards that have been set for nursing homes receiving medicare and medicaid are already minimal standards. From my frequent visits to nursing homes I can assure you that most of them are just within the letter of the law. There are very few facilities that provide more than they are required to do. This usually occurs in a private or religious affiliated home.

I can accept the fact that budget problems occur, for the most part, for a facility being unable to give services above and beyond that which is required.

However, when a deficiency exists the facility is providing care which is below the level of care which all of us agree is a bottom line standard.

When a resident is in his eighties or nineties suffering from chronic disabilities and must endure inadequate personal care, lack of concern for his quality of life, an environment that may be unsafe or uncomfortable, is it fair that we say that the facility is given a reasonable amount of time to correct the deficiency?

How long is reasonable when you are confined to a bed or wheelchair, unable to perform the simple activities of daily living?

I do not feel that a private agency such as JCAH which will be paid by the facilities and which has as its members many private interest groups is the proper organization to evaluate homes as I see a conflict of interest.

Also, I cannot equate the standards that are used to evaluate a hospital with the standards that should be used for a nursing home.

The nursing home should be a home. It is a home for many years for those who can no longer live in their own homes.

In addition to having proper medical attention and care and a clean and safe environment, the resident is entitled to a warm, caring, life enriching and life affirming environment.

I have seen many clean and safe and sterile nursing homes where you will not find a speck of dirt or dust. The floors may be clean but often the residents are not. They are lined up in chairs, staring vacantly at TV. No one talks to them or bothers with them for hours.

Public access to inspection reports is another area that would be affected by proposed changes. The public would not be able to go in and look back at the inspection records over a number of years.

Also, access to those reports would be dependent on visiting the facility to examine the latest JCAH recommendation rather than having information readily available in a central location for the public enforcement agencies and licensure boards to examine.

New proposals also eliminate the automatic cancellation clause whereby the survey agency can end the provider agreement if a deficiency is not corrected 60 days after a final warning is given.

If this clause is removed from the regulations, either deficiencies would continue for an unspecified amount of time or the survey agency would have to close the nursing home and move the residents elsewhere.

Statistics in Essex County show that in December 1981 there were approximately 150 people in the community awaiting medicaid beds, 218 people awaiting medicaid beds in the county's hospi-

tals, and 243 people not medicaid eligible who were waiting for a nursing home bed as a private payer medicare patient.

These figures do not take into account the number of people who have not been in contact with the medicaid office. At any one time I have a list in my office of 25 to 30 people awaiting a nursing home bed in Essex County.

If a home must be closed, rather than forced to correct a deficiency, where will the residents of that home be placed?

The most important area I am afraid will be affected by these proposals is enforcement.

I am effective when I am called out to investigate and settle a complaint because if I cannot work out a solution with the administrator I have State enforcement procedures to back me up; the State ombudsman's office and the State board of health.

On many occasions I have had to go to them with complaints having to do with concerns such as inadequate nursing care, poor medical decisions such as allowing a patient to dehydrate by not taking proper medical measures, infraction of dietary regulations, negligence and unsafe management of patients with broken hips, lack of assistance in feeding, staff abuse, questionable finance charges, threats, problems with contracts, inappropriate discharges, and enforcement of the indigent bed law.

At present the State is very responsive to complaints from my office. I am able to follow up at the State level and get results within a short period of time.

The administrators of nursing homes are well aware of this. It is in their best interest to work with me in solving complaints.

If the State gets less money for certification and surveys, I am concerned that there will be less money for enforcement.

JCAH says they will not monitor and enforce. Even if they were to decide to become involved with enforcement, local advocates such as myself must have staff personnel familiar with our homes and our specific problems to go to with complaints and sanctions. That is why we are effective.

If JCAH is allowed to replace the present enforcement procedures with a consulting service, the States will still have to be staffed and ready to intervene when there are problems, if they are going to fulfill their responsibility to the nursing home residents of the State.

I find it difficult to see how they can be effective on a day-to-day monitoring basis if they are not paid for providing service in the same way that they are now receiving funds.

These new proposals still retain the State's function as an enforcer of standards. However, with the budget cuts affecting many service providers, I am concerned that the money given to the State agencies for enforcement will be reduced or diluted to the point where we will no longer be assured of prompt responsive resolution of complaints.

I recommend that the nursing home regulations are kept similar to the way they are now written. Any changes which are made should be concerned with strengthening enforcement procedures and making them more effective.

Monitoring by the State agency seems to be working well.

I would see a definite advantage in the development of more ombudsmen projects at the local level.

Although funding for our center comes from the county, it is most important that the advocacy program is administered through a nonprofit private agency because I as an advocate work independently from any pressures from any personal interest groups.

I also recommend that figures be made available to show more accurately how much money could be saved by these proposals, over how long a period this money would be saved and, most important, how much money the States would be given to maintain their commitment to the monitoring of compliance with present nursing home standards.

There are approximately 230 nursing homes in the State of New Jersey which are receiving income from Federal, medicare, and medicaid programs which would be affected by these changes in the nursing home regulations.

In 1980 the Health Care Financing Administration issued a preliminary notice about the proposed revisions in certification and survey procedures contemplated at that time.

The statement made at that time was, "Our aim is to make these procedures more effective in improving the quality of care, less costly, less confusing to the consumer, and less burdensome for the industry."

To me this statement indicates an acknowledgement by the Federal Government that it is committed to insuring nursing home standards compliance.

In the face of a huge public outcry last spring, Secretary Schweicker refused to sign proposed regulations which would have weakened the standards of care on other areas of nursing home regulation.

I feel the Federal Government has a definite responsibility to honor its commitment to improving the quality of life for residents of our nursing homes.

Thank you.

Mr. FLORIO. Thank you.

[The prepared statement of Ms. Vogelmann follows:]

PREPARED STATEMENT OF JACQUELINE VOGELMANN, MA, CRC, DIRECTOR, NURSING HOME ADVOCACY CENTER OF ESSEX COUNTY

POSITION STATEMENT RE: SUBPART S-PROPOSED CHANGES OF FEDERAL SURVEY AND CERTIFICATION PROCEDURES

As the Director of the Nursing Home Advocacy Center of Essex County, I work on a daily basis with the issues surrounding nursing homes in this area. My work involves visiting the nursing homes, placement of residents into these homes, following up complaints or problems, working with the families of nursing home residents, and working with the residents, themselves. I have an active corps of volunteers who go into the nursing homes, and I co-sponsor a Community Information and Support Group for adult children and other caregivers who are involved with frail elderly people.

I feel that I have a realistic awareness of the positive aspects and problem areas of nursing homes in this county. I also feel that many of the changes that have been proposed in the Federal Register would not be in the best interests of the nursing home residents and might very well have detrimental results. These residents are a frail vulnerable population and need all of the protection that their government can give them.

Current regulations provide that nursing homes are reviewed once a year to see that they meet federal standards. The new regulations call for more flexible surveys, which would allow surveys to be done as infrequently as every two years. In the year that I have been the Nursing Home Advocate for Essex County. I have seen homes that were highly recommended and run very well, begin to slip and become shabby. Carpeting became torn, walls started to peel, food trays were untouched, an unpleasant odor appeared, or the staff simply was not responding with the same caring attitute as had been done previously. I have also observed a facility with many problems undergo a drastic change for the better over the year. These changes can occur very quickly if there is an administrative change or a change in key staff personnel. The Director of Nursing, for example, can set the tone for the attitude of the entire nursing staff. The average nursing home resident stays in the home for two years. It would be possible, with these new proposals, for a resident to live in the home and never have direct access to an inspection. In the same area, the proposals would remove the requirement of a 90 day resurvey when a provider is out of compliance. When a resident is in his 80's or 90's, suffering from several chronic or severe disabilities, and must endure inadequate personal care, lack of concern for his quality of life, an environment that may be unsafe and/or uncomfortable, is it fair that we say that the facility is given a "reasonable" length of time to correct a deficiency? How long is "reasonable," when you are confined to a bed or wheelchair, unable to perform the simple activities of daily living?

I do not feel that a private agency such as JCAH, which will be paid by the facilities, and which has as its members many private interest groups, is the proper organization to evaluate homes, as I see a strong conflict of interest here. Also, I cannot equate the standards that are used to evaluate a hospital with the standards that should be used for a nursing home. The nursing home, ideally, should be a home. It is a home for many years, for those who can no longer be in their own homes. In addition to having the proper medical attention and care, and a clean and safe environment, the resident is entitled to a warm, caring, life enriching and life affirming environment. I have seen many clean, safe, and sterile nursing homes, where you will not find a speck of dirt or dust. However, the residents are lined up in chairs starting vacantly at a T.V. and no one talks to them or bothers with them for hours. The floors may be clean, but often the residents are not.

The most important area that I am afraid will be affected by these proposals is enforcement. I am effective when I am called in to investigate and settle a compliant, because if I cannot work out a solution with the Administrator, I have the State enforcement procedures to back me up; the State Ombudsman's office and the State Board of Health. On many occasions, I have had to go to them with complaints having to do with concerns such as inadequate nursing care, poor medical decisions (such as allowing a patient to dehydrate by not taking proper medical measures) infraction of dietary regulations, negligence in safe management of a patient with a broken hip, lack of assistance with feeding, staff abuse, questionable finance charges, problems with contracts, threats, inappropriate discharges, and enforcement of the Indigent Bed Law. At present, the state is very responsive to complaints from my office. I am able to follow up at the state level and get results within a very short period of time. The administrators of the nursing homes are well aware of this and it is in their best interest to work with me in solving these complaints. If the state gets less money for certification and surveys; I am concerned that there will be less money for enforcement. JCAH will not monitor and enforce; it is not their policy to do so. They have one regional office in Chicago. Even if they decided to become involved with enforcement, local advocates such as myself, must have staff personnel who are familiar with our homes, and our specific problems to go to with problems and sanctions. That is why our program is effective.

I recommend that the nursing home regulations are kept similar to the way they are now written. Any changes which are made should be concerned with strengthening enforcement procedures and making them more effective. Monitoring by the state agencies seems to be working well, and I would see a definite advantage in the development of more ombudsman projects at the local level. Although funding for the Nursing Home Advocacy Center of Essex County comes from the county, it is important that the advocacy program is administered through a non-profit private agency, because the advocate must work independently of any pressures from special interest groups.

In Essex County, I often handle over 100 calls per month to The Nursing Home Advocacy Center. In addition to providing an extensive advocacy service, I run a program for volunteers in nursing homes and I Co-sponser an Information and Support Group Seminar series for caregivers in the community. When it becomes neces-

sary to refer someone to another county or to get information from another area of the state, I run into a problem because most of the counties do not have an advocate who deals with issues of long term care. I also hear from many out of county people who ask why this service is not available in their own locality. A strong network of local nursing home advocates would be an effective mechanism for providing uniform services to all of New Jersey's frail elderly population, and for keeping the state agencies informed about local problems.

As we have seen in Essex County, it is possible and beneficial to combine the work of the Nursing Home Advocate with that of Volunteer Coordinator for nursing homes. We have found that our program is more effective and responsive to the needs of the nursing home residents because of the involvement of the volunteers, and because this office serves as a resource center for nursing homes, in addition to its monitoring function.

STATEMENT OF MARGARET LUCK

Ms. LUCK. Thank you. I would like to extend my thanks on behalf of the executive director of the Camden County Health Services Center.

Perhaps it might be expected that as a nursing care facility we would be almost joyous at the elimination of an annual requirement because inspections can be unwieldy. We are most adamantly advocating continuation of inspections, though we are convinced that our facility is fine and that we are in compliance with regulations of both the State and JCAH.

Nonetheless, we recognize that the firmament extend farther than the county of Camden, and we are committed to an annual inspection if it means other facilities in an area of the States—or country—that are not up to standard must be kept so by means of an annual inspection.

We do have concern, though, that there be continuity, that we are not under regulations of several inspection teams.

The language is difficult to interpret. It is difficult to understand what something means when you try to implement changes for licensure.

We like the idea of one regulatory body so we are not continually bouncing back and forth.

We have just gone through rigorous back-to-back inspections by both JCAH and the State, and it is difficult, when you know that your facility is up to par and that you are providing adequate and good care, to endure the paperwork, the manuals, revisions, and the rigors of interview.

When each body has a different set of standards or interprets the same standard differently, then it is difficult indeed to know who you are pleasing when the point, of course, is to provide the best patient care possible.

We suggest that as a compromise if an annual inspection turns out to be not the way of the world that we have an inspection every 2 years and that we be able to send one or more of our staff to a continuing education program so that we are continually updated as to changes in standards—that we are aware of the language and meanings and interpretations to apply.

We prefer inspection tours whereby the State goes out and visits each facility and each department—we have several buildings.That we would absolutely require to be continued.

The recommendation of the administration is that staffing patterns be submitted on a regular basis once or twice, not only when asked for by the State.

As to whether the inspection should be conducted by either JCAH or the State, there is a consensus on JCAH. However, the question is, of course, accountability as the State is accountable to the people. That was a major question for us.

As a consensus to you I can say the administration of the county health services system would prefer the services of JCAH.

Yet, we also have concern about meeting the cost of JCAH inspections since it is funded by the institution. There are other institutions, though we may be able to carry that—they may not.

Again, as Betty said, we have decided that brevity is the better part of witnessing valour.

As far as answering technical questions, I do not feel competent to answer them, both because of my tenure and my position. However, we would like to provide either of you any further information that you need for the record.

[The following material was subsequently received from Ms. Luck:]

CAMDEN COUNTY HEALTH SERVICES CENTER,
Blackwood, N.J., July 26, 1982.

Hon. JAMES J. FLORIO,
Longworth Building,
Washington, D.C.

DEAR CONGRESSMAN FLORIO: May I iterate our thanks to you and to Congressman Hughes for the invitation extended to the Camden County Health Services Center to testify before the Public Hearing held Friday, July 16, 1982.

As we did not provide to you a written testimony, I hope that this letter will suffice as a summary.

1. Again, CCHSC advocates the continuation of an annual inspection. Although a two year period between inspections might be appropriate for those facilities which are up to standard, we agree that too many nursing homes require constant watch.

We also question that the State (or other Survey Agency) would indeed concentrate on homes with histories of poor conditions.

As well, we realize that even the best maintained home might become lazy if inspections are two years apart.

2. As regards reinspection our position is thus: The discussion about nursing home regulations evokes emotional rather than rational responses. We do not deny that negligence, abuse, and starvation of patients absolutely requires an on site reinspection to assure th t such treatment is not recurring. However, if the manual for a certain department does not contain detailed goals and objectives, or if personnel files are found to be incomplete, then deficiencies can be corrected by mail. The public is likely not aware that one team member on a survey team must read all the minutes from all the meetings which have taken place in a year. Surely corrections or additions to the minutes do not require on site reinspection.

3. As to whether the State or ICAH shall be the regulatory body, again, our position is that while this hospital might prefer JCAH, our concern is accountability. The State is accountable to the people, commonly, the tax-payers. To whom shall JCAH be accountable?

Also, it is our understanding that this state, at least, shall not relinquish its right to inspect, and we shall continue to avail ourselves of JCAH. The problem for many nursing homes thus becomes how to dance to the tunes piped. Paradoxically, our plea is that standards be uniform and generically applied and flexible.

Our population is both indigent and indigenous. Other nursing homes have other populations, structures, and staff needs. The uniqueness of each nursing home as regards the needs of its population ought not be obfuscated by a demand for "letter of the law" interpretation.

The beauty of one regulatory survey body would be the remission of irregularly interpreted standards. As it is now, compliance often depends upon the surveying team's preferences or arbitrary decisions.

(Note: We find it difficult to even interpret the language used. While a lot has been said recently about "bureaucrateese," it is true that the survey language is imprecise. Recently during a survey, one team member, while speaking about the chaplains, referred to "pastorial" duties. "Pastorial" is not even a word! We suggest that if the survey language were exact then compliance could be).

At any rate, we propose that continuing education seminars be held for nursing home staff that we may be aware of changes in standards and implementation.

4. Finally, present at the Hearing on Friday was Trudy Koerner who accompanied Betty Rice, Camden County Office of Aging. Betty Rice recruits and trains volunteers for CCHSC. The volunteers at any nursing home are the eyes of the community. As Community Service Outreach Officer, I also recruit, train, and place volunteers. I can cite several instances where volunteers have met with me to discuss hospital policy, patient treatment, or concern for any patient matter. While volunteers are not official survey teams, our hospital is overseen by those who are among the most dedicated in our society.

I do hope that this summary highlights how we at the Camden County Health Services Center understand and react to the proposed changes in nursing home regulations.

Your staff was most helpful to us as we prepared to come before you, particularly Mr. David Higham. Again, thank you.

Sincerely,

MARGARET L. LUCK,
Community Service Outreach Officer.

Mr. FLORIO. Thank you very much. I appreciate the testimony of all three witnesses.

I think a clear consensus is starting to evolve from some of our witnesses and yourselves as well that the nursing home area, really, over the last number of years, has improved rather substantially as a result of rather rigid regulations being uniformly enforced across the Nation.

I think we all know that those regulations in a sense came from some unfortunate scandals that occurred over the Nation in the nursing home area.

As a result, with the regulations we have now in effect, we have a lesser number of those abuses coming to our attention.

That is clearly to be distinguished from boarding home regulations where we don't have uniformity across the Nation the way we do in nursing homes.

The current phrase about, "if it ain't broke, don't fix it" probably applies most appropriately here. The regulations are working fairly well. Therefore there seems to be little reason to be modifying them and certainly modifying them down to the point where we might get back to the circumstances out of which the need for heightened uniformity arose; that is, the problems of inappropriately managed nursing homes.

I think your testimony reinforced that point and I appreciate your participation this morning.

Congressman Hughes?

Mr. HUGHES. Thank you. I, too, want to thank the panel for its very, very helpful testimony. And I suppose the basic question is at a time when the need for nursing home care is increasing, whether this is the right time to be cutting back on the checks and balances. That is the basic issue.

I am sure you were here earlier when I indicated that roughly $11 billion in savings are going to be achieved in medicare and medicaid in a bill just reported out yesterday by the Ways and Means Committee.

Much of those savings are going to be achieved by passing fewer dollars through to institutions.

I think it is safe to assume if you have had problems in the past with understaffing and for many services, particularly as administrations change in a nursing home, that that condition is only going to worsen.

I think your testimony was very pointed, just what strides we have made, and how important it is to the individual.

One assumption underlying these new proposed rules is that we can identify the abusers, the people that chisle, that do not comply, that sometimes permit services to slide gradually over a period of time. And we can identify them quite readily.

Yet if I understand you correctly you have indicated that those services can slide rather rapidly. And if you permit them to slide for 6 months or 1 year it could have a profound impact.

Am I correct in that?

Ms. VOGELMANN. Yes.

Mr. HUGHES. Well, we thank you for your testimony. You have been most helpful.

Mr. FLORIO. Thank you very much. We appreciate your help.

We have completed the hearing for about half our witnesses. So I think it would be appropriate at this point to take about a 15-minute break and we will reconvene at approximately 25 after the hour.

The committee stands in recess.

[Recess.]

Mr. FLORIO. The subcommittee will reconvene.

We are pleased to have as our next panel of witnesses the following individuals: Barbara Frank, director of Information Clearinghouse, National Citizens Coalition for Nursing Home Reform; Dr. Carol Germain, board of directors, New Jersey State Nursing Association—I see we have a representative. We are very pleased to have Ms. Wright here. Sybil Shainwald, chairperson of the board of directors of the National Women's Health Network.

Is Mr. Sciarillo here? He is not.

We welcome this panel on behalf of the committee.

As with all of our witnesses, your statements will be made a part of the record in their entirety. We would ask you go forward in summary fashion. I would like Ms. Frank to be our first witness.

STATEMENTS OF BARBARA FRANK, DIRECTOR, INFORMATION CLEARINGHOUSE, NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM; BARBARA W. WRIGHT, R.N., EXECUTIVE DIRECTOR, NEW JERSEY STATE NURSE'S ASSOCIATION; SYBIL SHAINWALD, CHAIR, BOARD OF DIRECTORS, NATIONAL WOMEN'S HEALTH NETWORK

Ms. FRANK. Thank you. My name is Barbara Frank. I serve as director of the Information Clearinghouse for the National Citizens Coalition for Nursing Home Reform. Our coalition represents 98 member groups in 28 States and has over 300 individual members across the Nation. Our goal is to improve the long-term care system and the quality of life for nursing home residents.

The coalition is pleased to have this opportunity to offer its views concerning recently proposed Federal regulations which would significantly alter the medicare and medicaid survey and certification process. As a native of Bayonne, N.J., I am particularly pleased that you and Congressman Hughes have taken leadership in stating concerns about these most important issues.

What I will do in order to save time today is to condense my remarks and focus only on several important issues, the importance of the Federal role in insuring quality of care or for long-term care residents, and then look at what an effective enforcement system should have as its essential ingredients, then look at what our problems are with the proposed regulations in terms of what alternatives could be because what we feel most strongly about is that the options chosen by the Federal Government are not the only options that are available to us. In fact, they are among the poorest options. So we will present to you a few of the options which we wish that they would consider today.

Finally, I will ask some questions which I hope that the Joint Commission on Accreditation of Hospitals will have an opportunity to answer in its testimony; also raise some questions that we have about the answers that Mr. Morford gave you this morning from the Federal Government.

First of all, the stake that the Federal Government has in insuring quality of care in nursing homes is large. Fifty-seven percent of the funds spent on nursing home care in the course of a year come from Federal coffers.

Ten billion tax dollars are spent on nursing home care each year. That is a tremendous amount of revenue. It is a tremendous stake the Federal Government has in insuring the money spent goes for quality care.

Our coalition in presenting our comments and looking at the broad range of concerns we have reflects the concerns and day-to-day experience of citizens all around the country.

The concerns that you have raised here in New Jersey are not just statewide issues. They are national issues.

We have found this to be the case by talking with consumer groups, talking with ombudsmen programs, by talking with State surveyors, by talking with people who live in nursing homes.

So the points that have been so ably made this morning are relative across the country.

Also the concern that we have is a concern that has been expressed nationwide. There are 44 national organizations in Washington, which have endorsed our position stating that the administration should drop the proposed regulations. A list of these organizations is attached to my prepared statement.

These national organizations and over 100 State and local organizations have said these proposals will not work, drop them; do not turn back the clock. Instead, reconsider, rethink these proposals; come up with something better.

It is frustrating to us that the administration has not considered alternatives. What is alarming to us is that perhaps the direction HHS has chosen indicates a reduction in their concern for vulnerable persons in our society. So let us look at what the Federal stake is.

I have already stated that the amount of revenue which is used for nursing home care is great. The Federal fiscal stake is substantial.

Beyond that, this is a critical time for us to see the Federal Government move in terms of strengthening nursing home standards rather than weakening them.

For one thing, the population in nursing homes is becoming much more vulnerable, much sicker, according to findings of the General Accounting Office.

Another factor is that funds to the nursing homes are being cut. So right now we have a population which needs more services and is less able to speak for itself. And we have nursing homes which are receiving less funds to carry out services and are looking at ways to cut corners just in order to be able to meet a diminishing budget; both those things happening at once.

And this is at a time that the Federal Government chooses to relax its standards rather than increase its oversight. To us that just does not make sense.

Federal oversight is important because the capacity of States to enforce varies greatly. The State of New Jersey has a fine record in terms of its enforcement capabilities. Other States do not.

We are a mobile society. We have relatives that live in different States. It is not good commonsense to say what is OK in New Jersey is sufficient for us and we should not worry what is happening in another State. That is why I am particularly pleased that your committee is looking at this whole national issue.

We have to be assured that as our relatives move from one nursing home to another, from one State to another, we have good quality care options available to them.

Another reason why the Federal Government should be concerned, instead of just relying on the States, is because nursing homes are starting to cross State lines.

Ownership of nursing homes is becoming more and more based in corporations. What that means is that policies are being set in one State that affect the kind of care being given in another State. All the more reason why there needs to be some Federal oversight.

Consumers of nursing home care are not in the strongest position to be able to choose the type of quality care that they need. We all know that by commonsense.

We don't necessarily choose when we want to go into a nursing home. We don't always have a full range of choice as to which nursing home to go into.

Furthermore, consumers lack basic information about the quality of care in nursing homes. So that it is very difficult to make a choice.

The Federal Government has a responsibility to its beneficiaries to insure that the choices that are available to them are of good quality.

HHS contends in its proposals that these proposals do the following things. That they reduce unnecessary paperwork, reduce burdensome regulations, contain spiraling health care costs, and they will provide State agencies with flexibility which will enhance their effectiveness and efficiency.

We contend these are just catchwords, that these are actually invitations to disaster.

Shifting greater responsibility to the States at the same time States lose essential funding for those responsibilities, or turning the system over to a private accreditation body can only increase the enforcement problems we have rather than to build a better enforcement system.

The problem with the current system is very simple. It does not look at the actual quality of care the patients receive. It is not built, structured in a way that can do that.

The Federal Government has heard this concern. It has been raised in countless studies by congressional committees, academicians.

HHS itself has written studies which state this very point. Yet the proposed changes the Federal Government is making right now do not address that.

They do not change the nature of the survey system. Instead they weaken it by knocking out the few teeth that the survey system has, taking away the few enforcement mechanisms that do exist.

We do not see this at all as a step forward, but as a step backward.

Let's look at what an enforcement system should have. The comments that I will make right now are based on survey results that we have from surveyors across the country who, on a day-to-day basis are inspecting nursing homes. They are also based on the findings of our resident council groups, family member groups, people that have day-to-day experience with nursing homes and working with the enforcement system.

They have identified several ingredients of an enforcement system. There must be cohesive, coordinated mechanisms to assure the review of conditions, services, and care at facilities.

To assure that corrections of deficiencies are made and to be able to respond to complaints and questions by consumers there must be maximum public information about the care provided by the community facilities.

There must be convenient access by the public and consumers to those responsible for determining compliance with standards.

There must be clear, specific, unambiguous standards that are easily understood by facilities staff, by surveyors and by the public.

The public must be included in the development and implementation of standards and the survey system.

There must be a broad range of powers to assist in correcting the diverse problems in nursing homes.

There must be a rational relationship between enforcement of standards and payment for services.

And there must be a day to day accountability for tax dollars and there must be a clear assurance that the rights of residents are protected.

Those are not impossible goals to achieve. In fact, they are very common, basic, simple goals, goals that say that the Government should be of the people, and it should be for the people.

They are saying that the enforcement system should do what it sets out to do and should be responsive to the public in the process.

There are several ways that the Federal Government could achieve this. These are proposals that are not new, proposals that have been bandied about for years, proposals that we have gleaned from responses that we have gotten across the country.

For one thing, we would advocate that the Federal Government consider instituting a patient care assessment program. It has been on the drawing board at HHS for over 10 years. It is called patient assessment care evaluation. It is part of a patient care management system.

The proposal is to set up a way of evaluating what people need and then directing the resources of the facility to meet those needs. Then on a periodic basis see to it that the services have been of good quality and reevaluate the needs of the resident.

That is a very simple premise, one we would assume has already taken place in nursing homes.

Unfortunately the Federal standards do not put that into place.

What we would advocate is that the Federal Government pull out from its back drawers all the studies it has done on its program and put it into place so nursing home standards reflect a coordinated process of care delivery, then devise an enforcement system that measures the quality of that systematized program.

Another possibility is to have the survey cycle in nursing homes so that there is an opportunity for a regular visitation into the nursing home, but that there is not full survey all the time, the specialists who come in and look at how their area of speciality is doing, and at the same time be able to evaluate the overall conditions on a gut level in the nursing home.

If there is need for more thorough review they can send an expert in to take a look at that.

Other proposals. One very essential proposal would be to require training for nursing home staff and to establish minimum patient-staff ratios.

Staffing in nursing homes is the most critical issue to quality care.

There also needs to be training for surveyors. And the composition of a survey team must be adequate to evaluate the kind of care that is provided.

Other ideas include developing either a systems oriented approach to surveying or problem oriented approach to surveying, or incorporating medical review findings, incorporating the findings of consumer advocates or ombudsman programs.

There also must be a range of enforcement capabilities. Instead of taking away the two or three enforcement tools the States now have, the Federal Government should go the other direction and establish a range of possibilities so that the State can invoke a penalty which suits the situation rather than have very few alternatives, one of them being to close the facility down which is really in many cases not an alternative at all.

These are the options that are available to HHS. There are others, a long list, too long to enumerate.

What we say to HHS is go back to the drawing board. If you have a real clear commitment to care of nursing home residents, then figure out a system that will work. Don't take the system that we have right now and gut it.

It is true that these proposals that have been submitted by HHS have been under consideration for a long period of time. They have been the issue of public debate for 2 or 3 years at least. However, there were many concerns that have been raised throughout that debate that are not reflected in the proposals.

That is once again why we say to them go back to the drawing board.

I do have some questions about the responses that the Health Care Financing Administration and the Joint Commission on Accreditation of Hospitals have given us for the questions we have raised about the soundness of the proposals that are before us.

I would like to raise them and hope there will be an opportunity to have an airing of answers to these questions in the course of this hearing.

HCFA maintains that no home will be allowed to continue with life-threatening deficiencies in its flexible survey cycle. It argues that right now 20 percent of nursing homes are superior.

We question why they are classified as superior when the fact is that they merely comply with minimum basic standards in accordance with a contract they have signed.

Facilities that don't have any deficiencies in their minimum standards, are considered superior. I would call them just average facilities.

There certainly are superior facilities around the country. However, the Federal Government does not have the capacity to measure that because of the flaws in the current system.

My question to the Health Care Financing Administration is how does HCFA rank quality of life on the scale of deficiencies deserving public scrutiny? How does it consider quality of life when it says that no life-threatening situation will occur?

In order to make this point I wish to read to you a comment that was sent into us by a resident of a nursing home in New York City. She represents the Coalition of Institutionalized Aged and Disabled, a resident council group in New York. She writes:

> We need annual surveys and we need automatic surveys. It is hard for us to listen to the administration speak in an offhand way about concentrating only on life-threatening situations and poor facilities. Who is going to define what is life threatening and what makes a facility poor? You can be sure it won't be us, the nursing home residents, who know what threatens us and what it is like to live in a bad facility.
>
> We would question the administration as to whether a resident who has to wait for hours to go to the bathroom or is left in wet clothes or is inadequately clothed, whether these are life threatening conditions or simply inconvenience.
>
> Certainly no one in the community would put up with these conditions. Yet we, the nursing home residents who have lived so long should have to grit our teeth and do the best we can. The least the government can do is to survey our homes once a year to make sure deficiencies are corrected within a specific period of time.

We asked questions of the Joint Commissioner on Accreditation of Hospitals about the proposal. The Health Care Financing Administration maintains this is a cost savings. However, we have seen that the facility which accepts accreditation from the Joint Commission is reimbursed through medicare and medicaid funds. Is that a cost savings or a cost shifting?

How can the Health Care Financing Administration justify taking money from funds for health care benefits while pretending to save money by reducing survey budgets?

The Joint Commission on Accreditation of Hospitals maintains it does have public membership and representation on its advisory boards by consumer organizations that are supposedly accountable to the public.

I would like to question the Joint Commission: Who is your public member? How is he selected? What does he do to represent the public? How does the Joint Commission solicit public comment and incorporate those comments into its decisionmaking process?

If it feels it has such a strong, confidential relationship with facilities that it cannot release survey reports to the public or to the Federal Government or the State government, how is it then more accountable to the public?

The Joint Commission also argues that it has an effective complaint investigation system. We would like to question how many complaints does the Joint Commission receive on a yearly basis. How many does it investigate onsite? What are its complaint investigation procedures? What is the time frame for these investigations? How does the Joint Commission protect the confidentiality of complainants?

We do not take issue with the Joint Commisson as a private body which provides consultation and education to its membership. We do take issue with its use as a regulatory authority when it states itself it does not wish to be a regulator.

Well, I have shared with you our thoughts about what an effective enforcement system should do, what the Federal Government should do now instead of proposing the regulations which are before us, and raised some questions about the proposals that the administration has put forward.

In closing let me say we are reassured by the commitment Secretary Schweicker made to the American public on March 22, 1982, when he stated that he would not remove essential Federal protections.

He said, "I will not turn back the clock." In fact, it is clear that every Secretary of this Federal agency over the last 15 years has taken steps to improve the system. These moves have often been at the urging of congressional leaders who have upheld Federal responsibilities established under the Social Security Act.

In fact, every congressional hearing on this issue has been conducted to review and affirm Federal priorities in this area.

We commend this committee for continuing this leadership and in advocating Federal protection for nursing home residents.

Now we urge Congress once again to provide direction to HHS to change its course.

As we said in our position statement, it is our belief that the rule changes proposed by the Department of Health and Human Services on May 27 would over time imperil nursing home residents.

The citizens of this country would all support congressional leaders in this effort. We would all do our part to support more rational and humane proposals.

[The prepared statement of Ms. Frank follows:]

TESTIMONY OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

BEFORE THE U.S. HOUSE OF REPRESENTATIVES SELECT COMMITTEE ON AGING

Blackwood, New Jersey July 16, 1982

Presented by Barbara Frank

My name is Barbara Frank. I serve as the Director of the Information Clearinghouse for the National Citizens' Coalition for Nursing Home Reform. Our Coalition represents 98 member groups in 28 states and has over 300 individual members across the nation. Our goal is to improve the long-term care system and the quality of life for nursing home residents.

The Coalition is pleased to have this opportunity to offer its views concerning recently proposed federal regulations which would significantly alter the Medicare and Medicaid survey and certification process. We commend this Committee for making this forum available to those concerned with the continuing viability of Federal oversight of over 10 billion tax dollars which are expended on nursing home care yearly. The least that the public should expect from this enormous public investment is that adequate, appropriate and decent care be provided to a population which the Secretary of Health and Human Services himself has described as "our most vulnerable."

In framing our comments today, the Coalition relies upon the wealth of day-to-day nursing home experience of our membership. In addition, we have regular and substantial contact with most state long-term care ombudsman programs. Further, we are guided by the thoughtful comments of dozens of state survey inspectors and officials who responded to a recent NCCNHR questionnaire about the proposed Subpart S regulations. Copies of this questionnaire and the survey analysis will be submitted to the Health Care Financing Administration as part of the Coalition's formal comments on the proposed regulations. We will also submit this information to the Committee as soon as it is completed.

Today we submit with this written testimony a Position Statement initiated by the Coalition which has been endorsed by 44 national and over 100 state and local organizations. This statement, delivered to Secretary Schweiker on July 12,

calls upon HHS-HCFA to rethink its Subpart S proposals which endanger essential protections for nursing home residents. Representative groups signing the Position Statement include the American Association of Retired Persons, National Council of Senior Citizens, National Gray Panthers, National Association of Area Agencies on Aging, National Caucus and Center on Black Aged, the National Council on Aging, and the Consumer Federation of America. In addition, several religious organizations, unions and other varied organizations are included in the list of endorsements attached to the Position Statement.

There is no question that current standards of care and the survey and certification process need improvement. The current system fails by design. It does not assess the actual care patients receive. The proposals at hand compound the current inadequacies by utilizing the existing enforcement system on a less frequent basis. This severely weakens an already anemic system. The proposals would leave nursing home residents in far too many facilities with fewer safeguards to ensure that the minimal care they now receive will not be decreased in quality or quantity.

There are several reasons why we believe that leadership in an effective enforcement system must be at the federal level.

1. Clearly, the federal government's fiscal stake is substantial. 57% of all nursing home revenues derive from its coffers - from Medicare and Medicaid alone. On top of this amount, millions more are expended through other federal programs which among other benefits have provided substantial construction loans to facilities. The minimal monies now spent and projected for federal/state survey and certification programs is merely a drop in the bucket compared to the billions spent annually.

2. Recent information from the General Accounting Offices reveals that a projected increase in the population of nursing homes will be sicker, much older and more vulnerable because of disabling conditions.

3. Recognizing these demographics, the 1981 White House Conference on Aging also stressed the role of the federal government in long-term care. Recommendation Number 176 stated:

"Quality assurance is essential to the provision of appropriate, effective and efficient services to the at-risk elderly. Care should be of sufficient quality and intensity so as to provide the degree of care needed by the individual to remain as independent as possible. Federal policy must continue to provide minimum standards of care to include a meaningful protection of rights of the individual to appropriate services." To implement this recommendation, the federal government must "continue to provide meaningful conditions of participation under Medicare and Medicaid statutes, strengthen and upgrade such rules and review statutes to ensure protection."

4. Federal oversight is obviously needed because enforcement capabilities vary dramatically among the states. Few states have the ability, without active federal support and guidance, to adequately assure that the system is working properly.

5. Clearly, the public which is concerned about nursing home residents understands the need and advocates for consistency and uniformity within a complex national system where reported problems are similar from state to state. As a result of our mobile society, many families are separated from one another. Persons with relatives or close friends placed in facilities in different states have a justifiable expectation that a uniform system will exist which assures at least a minimal level of care and protection.

6. Furthermore, families often interact with facilities in their state which are managed or controlled by persons or corporations sometimes several states removed. Nursing home owners, small partnerships or small corporations may own nursing home facilities in several states around its home base. Furthermore, the growth of large corporate owned nursing homes has been astronomic in recent years and is accelerating. Corporations based in one state may own and operate hundreds of facilities throughout the nation. It is clear that federal uniform standards, enforcement procedures and capabilities which

reinforce state systems are necessary to keep up with this national trend. Clearly, industry business practices would be simplified were the large chains able to rely on nationally uniform standards and enforcement procedures.

7. Consumers - Medicaid and Medicare beneficiaries - often have no practical means of exercising wise marketplace decisions. Routinely, the choice of a facility is made by others, and it is made not so much on the basis of seeking the best care, but rather on the basis of finding the only available bed. It is entirely wishful thinking on the part of HHS to believe that marketplace incentives for a facility to maintain its standards of care will substitute for the minimally adequate federally mandated monitoring which in the past has not been uniformly sufficient to ensure the receipt of decent, quality care for over 1 million nursing home residents.

HHS contends that its proposals result from the following goals: reducing the unnecessary paperwork and burdensome regulations, containing spiraling health care costs and providing state enforcement agencies with appropriate flexibility to enhance their efficiency and effectiveness. These are all laudatory goals...in the abstract.

We contend, however, that these catch words, as they are portrayed in the proposed regulations, are invitations to disaster for nursing home residents. Deregulating, shifting greater responsibilities to the states, or indeed, allowing a private, health care industry-oriented agency to hand out claim checks to the federal cash window to Medicare and Medicaid are not the answers for any current flaws in the enforcement system.

The principal shortcoming of the current standards enforcement system is also its most basic. It simply does not measure what residents receive for the billions spent on nursing home care. It merely focuses on paper compliance and assumes that if the facility has the capacity to deliver care (during the week or so of annual inspection time) then, in fact, adequate care is being delivered.

Countless studies; investigative reports of grand juries, legislative committees, and academics; as well as numerous HHS publications, and the practical experience of ombudsman programs and citizen programs throughout the country, belie this deductive relationship.

The main problem with the current system, which remains unaddressed by the HHS proposals, is that it does not focus on the quality of care actually received by residents. Inspections of nursing homes should be geared to determining whether residents are properly assessed, whether the care they receive is commensurate with their needs and that it is of high quality. The procedures offered by the Department are seriously inadequate to protect the care of many vulnerable people in nursing homes.

Our testimony today will address three primary issues raised by the proposed regulations:

I. Potential changes in the actual procedures to be used by state enforcement agencies;

II. The availability of funding to ensure inspection capability; and

III. The proposed option of deemed status whereby homes accredited by the Joint Commission on Accreditation of Hospitals would be eligible for certification under Medicare, and, if a state so opts under Medicaid as well.

I will summarize the written testimony which follows and submit my full testimony for the record. I will be happy to elaborate on any points about which you have questions.

I will also share with questions we have about points made in support of the Subpart S rule changes by HCFA, the JCAH, and representatives of the nursing home industry.

Further, one of our appendices includes excerpts from comments made by New Jersey surveyors in response to the questionnaire I mentioned earlier in my testimony.

I. Potential Changes in the Enforcement Process

Under the guise of introducing flexibility into the survey process and reducing the burden of regulation on business, HHS is proposing, among other things, to do away with mandatory annual certification surveys, eliminate mandatory site revisits to check the correction of deficiencies, excuse the reporting of quarterly staffing records, and relinquish the current automatic termination of certification for facilities which fail to meet timely targets for deficiency correction. In this testimony we have chosen to address the proposals relating to annual surveys, facility site revisits, and the automatic cancellation clause.

Annual Surveys

In the early 1970's, the Subcommittee on Long-Term Care of the Senate Aging Committee reported that as many as 50% of all nursing homes were regularly out of compliance with federal survey standards and that that same number were plagued by life threatening conditions. A 1975 HHS study conducted under the nursing home improvement campaign made similar findings. Recently, an official of the Health Care Financing Administration stated at the NCCNHR annual conference that 35% of federally certified facilities had serious deficiencies. He contended that only 20% of facilities actually met all minimal health and safety requirements. The Coalition's experience and the sordid public history of nursing home problems demonstrates clearly that even annual surveys are not sufficient to maintain standards in a substantial number of facilities.

The Coalition's questionnaire to state surveyors asked whether surveys influenced compliance with standards and whether facilities would maintain standards if surveys were less frequent than the currently mandated annual review. Ninety-six percent [96%] (47 of 49 respondents) replied that annual surveys did influence compliance with standards and ninety-seven percent [97%] (46 of 47 respondents) felt that less frequent surveys would lead to

lower standards maintained by facilities. According to one of our surveyor responses from New Jersey, "Compliance with standards would not be the rule but the exception if annual surveys were not done. Standards which impact on finances would be complied with marginally until cited at survey time."

A Missouri surveyor reported that, "program experience has shown that facility operations change from one survey to another due to personnel probelms, competition, financial difficulties, etc."

HHS proposes a two-year survey cycle purportedly leaving states the flexibility to inspect historically problem facilities more frequently. Notwithstanding the fact that many state survey agencies have already been decimated by federal budget cuts, this proposal misses the mark of rationality. The Coalition of Institutionalized Aged and Disabled, a group of 100 nursing home resident councils in New York, in its written remarks which we now submit to this Committee, offers a compelling reason against the proposed HHS two-year survey cycle.

CIAD comments that nursing homes are volatile, fluid environments. Staff turnover throughout the industry is notoriously high. Changes in key staff - administrators, directors of nursing, dietary supervisors or housekeepers usually have dramatic, overnight impact on the care delivered in that nursing home. "Good" facilities which overnight might acquire new staff and go for two years without an inspection may breed outrageous conditions during that period. Additionally, the failure to survey would deprive the new staff of the guidance and consultation of experienced surveyors. The need for regular, comprehensive and frequent surveys is best stated by the residents' coalition:

> We need annual surveys and we need automatic surveys. It is hard for us to listen to the Administration speak in an off-hand way about concentrating only on life-threatening situations and poor facilities. Who is going to define what is a life-threatening situation and what makes a facility poor? You can be sure it won't be us, the nursing home residents, who know what threatens us and

> what it is like to live in a bad facility'. We would question the Administration as to whether a resident who has to wait hours to go to the bathroom, or is left in wet clothes or is inadequately clothed, whether these are life-threatening conditions or simply inconveniences. Certainly no one in the community would put up with those conditions, and yet we, the nursing home residents who have lived so long, should have to grit our teeth and do the best we can. The least the government can do is to survey our homes once each year to make sure deficiencies are corrected within a specific period of time.

Daily, the Coalition receives similar comments from all over the country which decry this proposal for a less than annual survey. It is ironic that the federal government would go so far to relieve nursing home owners and operators - who are voluntary contractees - of the necessity of oversight rather than to ensure that contractees fulfill their agreements to provide decent care under Medicare and Medicaid.

Assuming even the best of intentions among nursing home operators, the Secretary owes the elderly and disabled, the frail and infirm, a broader degree of caring. HHS must preserve rather than destroy the safety net which assures minimal implementation of standards.

New and Tested Changes Could Offer Improvements

Based on our own analysis and from information recently received from state survey agencies, there are clearly changes which could be considered relating to the frequency and quality of surveys. For example, a South Carolina surveyor recommends, "Facilities should have a full survey at least every other year with a partial survey on the alternate years. If not surveyed at least partially on a yearly basis, most facilities become lax in some areas. The partial survey alternating with the full survey could spot any weak or potentially weak areas in one year which could be surveyed more closely on the following year."

Another surveyor from North Carolina suggested, "90% to 95% of all [facilities] should be surveyed annually or within a time frame of from

9 to 15 months. This would allow more flexibility in the survey schedule, and it would be more difficult for a facility to pinpoint the approximate date of our next visit."

Another innovation which would significantly improve the HHS standards enforcement system would be its re-focus on the actual care delivered to nursing home residents. HHS has the capacity to provide facilities with the necessary information and instruments to systematically assess residents, assess appropriate goals for them, periodically evaluate progress toward those goals, and reassess resident needs. Indeed, since the early 1970's HHS has spent millions of dollars developing, refining and successfully field-testing the PACE (Patient Assessment/Care Evaluation) Program.

In 1980, HHS proposed a Patient Care Management System based on the PACE program. This proposal was never issued in final form-even with considerable public support. In a new draft Conditions of Participation for nursing homes, developed in 1981 and ultimately withdrawn, HHS promoted a Patient Care Management System largely along these lines. At the time, although the Coalition endorsed the concept of PCMS, we found its expression to be utterly valueless in the context of the entire Conditions which were substantially diluted. We therefore opposed its adoption in that form.

The principal value of PCMS would be the integration of an ongoing comprehensive facility-based resident assessment and review program with an enforcement system designed to determine that nursing home residents are being accurately assessed that care is appropriately planned, and that a reasonable quality of care is actually provided. Such a system would assure that the conditions of residents are continuously re-evaluated and care plans accordingly modified. In this manner, surveyors could determine the effectiveness and quality of the care actually received by the beneficiaries of federal programs. The level of care provided would surely improve (as many test facilities in the PACE program found). Certification decisions would

finally be made on the basis of rational inquiry into the fruits of the massive expenditure of our tax dollars.

Other ideas which HCFA could consider in developing an improved survey system include:

1) Requiring training for nursing home staff and establishing minimum staff to resident ratios.
2) Providing better training for surveyors and composing survey teams in such a way that all essential elements of nursing home care are covered.
3) Utilizing a systems-oriented approach whereby surveyors evaluate how services are designed and implemented.
4) Incorporating medical review findings into factors considered when determining compliance.
5) Clarifying standards and emphasizing a uniform approach to their application.
6) Focusing on a problem-oriented approach which would review how problems occurred, how they were handled, and how they could have been prevented.
7) Ensuring that ombudsman and consumer information is considered in compliance deliberations.
8) Establishing a range of enforcement capabilities from consultation through all degress of penalties and remedies.

90-Day Revisits and the Automatic Cancellation Clause

Currently, nursing homes found to be deficient during annual surveys are revisited within 90 days to determine that the problems noted have been corrected. While such revisits do not guarantee compliance with standards, their very existence poses a potent threat to those who might otherwise avoid compliance.

Allowing states to forego revisits and rely instead on telephone or documentary notice of corrections may be appropriate in limited circumstances. These situations, however, must be clearly specified if resi-

dents are to remain adequately protected. Too often an apparent "paper deficiency" or "isolated" problem may be a symptom of more serious systemic problems which only a revisit would detect.

Proponents of flexibility assert that a correction often takes longer than 90 days to complete, making a 90-day revisit fruitless. One thing is for certain: a revisit would document the progress that is being made (if any), or what interim action is being taken to correct the situation. Often, a pending revisit will stimulate an otherwise forgetful or obdurate nursing home operator to move toward compliance.

We have also heard arguments that many deficiencies cited are trivial and do not merit a revisit at all. Interpretations of triviality vary according to whose ox is being gored. But instead of eliminating an important enforcement tool, HHS should focus on the real problem and encourage and provide surveyor training to avoid citations for "trivial" deficiencies.

Of course, states should schedule revisits when necessary and timely. The Coalition fears, however, that with re-visits made optional, along with a longer survey cycle and smaller budgets, revisits will become rare, and diminished facility accountability will result.

The automatic cancellation clause is another enforcement tool eliminated by these proposed regulations. This provision is like a switch with a 60-day timer that the state agency will "switch-on" after it determines that a facility has repeatedly failed to correct deficiencies. In 60 days, the timer "runs out," and the provider agreement is automatically cancelled. The facility must correct the problem within 60 days in order to convince the state to switch the timer off. Whereas the burden has been on the regulatory agency, once the switch is "thrown" it falls to the facility to act.

90% - 95% of the time that switch is turned off before the provider agreement is cancelled. HHS argues that this is an indication of its ineffectiveness. In fact, this statistic proves how well it works: most facilities make the necessary corrections before the "timer" runs out.

Proposed regulations direct states to allow facilities "a reasonable time" to correct these types of deficiencies, which is consistent with the Federal policy of making many present requirements optional. But when money is tight, the budget may dictate program decisions. Minimum becomes maximum; optional can mean almost never. In fact, HHS has acknowleged this crucial tie-in between budget and program in a March 1981 memo (already in the possession of the committee staff). This memo urged states to adopt many of the current proposals as a way to live within the budget reductions of the past two years.

II. Budget Issues

While the specific make-up of the enforcement system is obviously related to the quality of care received by nursing home residents, poor funding for that system can effectively neutralize even the strongest provisions. Federal funding for Medicare/Medicaid survey and certification has decreased steadily since 1980. In that year, it was funded at a level of $67 million, with a 100% Federal match for Medicaid survey and certification expenditures. By 1982, the figure had dropped to $49.4 million with approximately a 70% match for state Medicaid costs.

In a recent telephone discussion with a HCFA official, NCCNHR requested specific data on costs of surveys under the current system. From this data, we computed the cost of surveying all facilities at the legal minimum to be $121.2 million. HCFA verified this figure. Yet, the Administration proposes funding this program at a level of $51 million for 1983.

Congress has the opportunity to provide an adequate funding level for these programs. The underfunding of the survey program is already diluting the impact of the survey system and causing states to adopt the proposals now before us on a de facto basis. States are sending smaller, less qualified survey teams out for shorter periods of time to conduct abbreviated surveys. A survey conducted by NCCNHR in March 1982 found that state agencies' loss of personnel has ranged from 15% to 50%. Five states specified loss of Life Safety Code experts. Without expertise in the Life Safety Code or in any other professional specialty, the quality of the survey will deteriorate; leaving open the possibility that poor care will go unchecked.

Furthermore, drastic cuts have been made in the staff of regional offices of HCFA. These offices have the responsibility to perform "Validation surveys" of surveys conducted by states and by the Joint Commission on the Accreditation of Hospitals. A recent internal report by HCFA points out that loss of 27 Commissioned Corps staff in eight regions has led to a 39% cut in the total number of surveyors performing full-time direct Federal surveys. According to the report, these cuts "would seriously jeopardize the continuation of responsible monitoring surveys" by the regional offices. In addition, the national office of HCFA has received cuts in staff with more cuts projected.

We question the good sense of defunding programs which are constructed to provide quality assurance and hold providers accountable to the public. $121 million dollars is less than one percent of the public monies spent on health care services. Yet, this is the money which ensures that the billions of dollars spent on health care are spent well.

III. The Proposal Regarding Deemed Status

The Administration's proposal to allow "deemed status" to facilities accredited by a private agency represents a dangerous abandonment of vulnerable nursing home residents as well as an enormous dilution of the accountability to which facilities should be held. A detailed analysis of this proposal will be submitted to HHS as part of the Coalition's formal comments. A copy of these comments will also be made available to this committee. In our testimony today, we will only summarize some of the important issues which are of public concern.

It is our firm belief that a system for the enforcement of nursing home standards which assures quality care and rallies the public's faith and confidence in it must have certain vital components. Among these are:

1) cohesive, coordinated mechanisms for a) the review of conditions, services and care; b) the correction of noted deficiences; and c) response to complaints and questions by consumers.

2) maximal public information about the care provided by community facilities.

3) convenient access by the public and consumers to those responsible for determining compliance with standards.

4) clear, specific and unambiguous standards which are easily understood by facility staff, surveyors, residents and the public.

5) the inclusion of the public in the development and implementation of standards and the survey system.

6) a broad range of appropriate powers to assist in correcting the diverse problems identified in nursing homes.

7) a rational interrelationship between agencies responsible for enforcement of standards and payment for services.

8) day-to-day accountability to the public, and to its elected and appointed officials, for the expenditure of tax dollars.

9) clear responsibility for assuring the protection and delivery of federal rights granted by federal statutes to nursing home residents.

In our opinion, no private agency can or should develop these components or assume these responsibilities of the government. Certainly, the proposal to grant "deemed status" to facilities accredited by JCAH does not fulfill these requirements.

Through its criticism of this proposal the National Citizens Coalition for Nursing Home Reform (and to its knowledge no other organization who supports our position) does not intend to quarrel with or question the routine work or goals of the Joint Commission on Accreditation of Hospitals. That organization undoubtedly fulfills an important function for those nursing homes which voluntarily choose to purchase its consultative and accrediting services.

We do oppose the proposed role of the JCAH in the federal survey and certification process. JCAH is a private organization dominated by health care provider interests. It has no enforcement or regulatory powers, nor does it feign interest in a regulatory role. The results of its surveys are confidential. The posting of accreditation reports by facilities, which HHS proposed mandating only in response to public outcry, will merely provide summaries of the most recent survey finding. It is unclear what information will be made available to state and federal regulatory agencies and in how timely a fashion. JCAH will be paid for its surveys by participating facilities (primarily out of government reimbursement funds). It may be severely strained to revoke an accreditation it has granted. JCAH has limited capacity to investigate complaints and incorporate its own complaint findings, or those of the ombudsman program or the state licensing agency, in its accreditation decisions. Its only office is in Chicago, Illinois, making it virtually unaccessible for consumers, long term care ombudsmen and consumer representatives. Meaningful relationships among ombudsman programs, consumer groups and state surveyors will potentially be destroyed or become irrelevant.

JCAH does not conduct annual surveys. The limited amount of information it will share with the public and state, regional and federal enforcement agencies would seriously undermine efforts to validate the effectiveness of its reviews. Enforcement and regulatory activities by state and federal agencies would by necessity duplicate survey procedures, severely straining budgets and already decimated staffs.

Of the surveyors responding to the Coalition's questionnaire 79% of the respondents reported experience with JCAH accredited facilities. Of these surveyors 93% thought the quality of JCAH surveys or the facilities they accredit to be poor. Many reported that JCAH, in their experience, did not respond well to complaints. Typical comments received from these surveyors are included in attachment 1.

The HHS proposal to allow "deemed status" is just plain bad policy and remains unsupported by rational evidence. JCAH experience in the accreditation of hospitals, which according to the Coalition's survey is not uniformly endorsed by the states, cannot and should not be used as a justification for its application to nursing home certification. It would place important decisions about the distribution of vast sums of public dollars in private hands. It would extinquish the availability of essential public information about the care practices of publicly financed nursing homes. It would, we believe, result in poorer care for thousands of nursing home residents. Most importantly, it would cripple the ability of public agencies to respond effectively to our elderly citizens who call out for protection and assistance.

The fact is that we already have a nationwide federal/state system for survey and enforcement of standards. Given the obvious difficulty of JCAH to operate from a central location in Chicago, it would be reasonable to assume that JCAH will, and indeed it will be necessary for JCAH to, establish a state and regional presence and capacity. In other words we may be witnessing the sowing of seeds of a duplicative, but private

bureaucracy. Surely with our limited public funds the Secretary of HHS does not propose taxpayer financing to fuel this wasteful and unnecessary replication of, or more ominously, substitution for, the already existing public system.

In closing let us say that we were reassured by the commitment Secretary Schweiker made to the American public on March 22, 1982, when he stated that he would not remove essential federal protections. "I will not turn back the clock," he said. In fact, it is clear that every Secretary of this federal agency over the last 15 years has taken steps to improve this system. These moves have often been at the urging of Congressional leaders who have upheld federal responsibilities established under the Social Security Act. In fact, every Congressional hearing on this issue has been conducted to review and affirm federal priorities in this area. As in the beginning of this testimony, we commend this Committee for this significant hearing and for its continued leadership in advocating for federal protections for nursing home residents.

Now we urge Congressional leaders to once again provide direction to HHS to change its course. As we said in our position statement, "It is our belief that the rule changes proposed by the Department of Health and Human Services on May 27 would, over time, imperil nursing home residents."

The citizens of this country will all support Congressional leaders in this effort and will do their part to help build a better system, based on more rational, humane proposals.

NCCNHR SURVEY OF STATE NURSING HOME SURVEYORS

-Preliminary Findings; July 1982

The following quotations are typical comments made by state surveyors when asked about the quality of surveys conducted by the Joint Commission on Accreditation of Hospitals (JCAH):

CALIFORNIA

* Accreditation by the JCAH is a purchased item. You pay for it, you get it. Their survey requirements are non-specific and nebulous.

* As a former director of nursing in several SNFs, I have nothing but negative comments regarding my JCAH inspections...There were never any communications regarding complaints, even though complaints were registered.

* Accreditation (by JCAH) does not adequately reflect the degree of compliance or non-compliance with regulations/conditions of participation.

* State agencies will retain their licensure responsibilities whether or not deemed status is granted. Consequently this would result in duplicate inspections as well as being less cost-effective.

MISSOURI

* JCAH is a private organization and accountable only to member facilities.

* Consultation between surveys will be limited due to distance of (JCAH) survey team.

NEBRASKA

* No monitoring by JCAH for correcting deficiencies; no unannounced surveys; SNFs and ICFs do not compare with hospitals in that they do not have daily physician contact and professional nurse coverage for supervision.

* I understand that JCAH provides an adequate survey; however, the facilities vary from excellent to poor as if the JCAH survey had no effect.

* How can a three-member team review a 60-bed hospital and an 84 bed long term care area in one six-hour day, and actually review the services as they are being provided?...These facilities hear what a wonderful job they are doing from the JCAH reviewers and we as certification surveyors follow behind listing all our problems with patient care, dietary, social services, etc.

NEW HAMPSHIRE

* I do not think JCAH does an in-depth survey of areas in a survey. It is a too-fast thing. This is based on my hospital experience.

NEW JERSEY

* (Of three JCAH accredited nursing homes), one maintains excellent standards...The other two...were recommended for decertification from titles 19/18 based on nursing care and staffing, dietary and infection control services at the same time they received JCAH accreditation. One of the two was also subject (to) licensing sanctions based on patient care. The other one was denied title 18 participation by HHS based on physical plant/ life safety code deficiencies.

* Surveys are conducted by appointment and based largely on documents submitted in advance by the facility. Their reports are not disclosable to the public.

* I feel it would be unfair to smaller facilities which could not afford the cost of a JCAH survey.

NEW MEXICO

* Six weeks following JCAH survey of a hospital, some of the deficiencies noted by this agency and not by JCAH were:

- 146 shifts did not have an RN assigned on one or more patient units;
- aides performing treatments, which is in direct violation of the New Mexico Nurse Practice Act;
- insufficient staffing throughout facility;
- 48 shifts for the emergency room did not have scheduled staff RN coverage.

I do not feel JCAH is qualified to conduct a survey if the above example is representative of their completeness of survey!

* We have enough evidence of (JCAH's) slipshod ways with hospitals in this state to indicate that they should not be anywhere else. Costs will not be decreased, but increased, for complaints will soar, will have to be investigated, and validation surveys and revisits performed by the state agency.

* I have never seen one (JCAH) surveyor on the patient floors or talking to one patient.

NORTH CAROLINA

* Some accredited nursing homes have stated that the JCAH dietary surveys are not what they should be.

PENNSYLVANIA

Nursing homes will become beautiful institutions and only warehouses to die! ... I can see the possiblility of "payoffs" between providers and JCAH.

SOUTH CAROLINA

* JCAH surveyors would not have the personal interest in the welfare of the resident, being based in another state. A body that certifies for pay may not have the best interest of the patients at heart ... It would be much more difficult (for the State agency) to follow up on (JCAH) findings.

SOUTH DAKOTA

* I feel (JCAH accreditation) is more prestige than actual function connected to their surveys. They do not spend enough time in a facility to evaluate quality of care.

UTAH

* JCAH is milktoast; administrators like JCAH because they are lax; more conceit than substance; no regulatory power; no complaint investigation.

* I have not heard that JCAH has ever closed a facility--lack of authority...little cooperation in sharing information...
I also feel that what I am doing is important to our society and I hope if the day comes when I am the patient in a facility that there is still an agency monitoring as thoroughly (as ours).

WEST VIRGINIA

* The JCAH survey is for prestige only. Their survey is liken to a walk through with eyes closed. They never check with the state licensing rules and regulations; even change some certification conditions of participation to suit their survey.

* Overall effect of the total package:

1. A cost saving to HCFA,
2. Increased costs to facilities to purchase JCAH surveys,
3. Reduction of the number of state surveyors,
4. Reduced level of care and staffing in nursing homes.

National Citizens' Coalition for
NURSING HOME REFORM

1424 Sixteenth Street, N.W.
Suite 204
Washington, D.C. 20036
202/797-8227

Frieda E. Gorrechi
President

Elma L. Griesel
Executive Director

July 12, 1982

Secretary Richard Schweiker
Department of Health and Human Services
Washington, D. C., 20201

Dear Secretary Schweiker:

Enclosed is a position statement endorsed by 44 national organizations and over 100 state and local organizations opposing proposed regulations which would revise the survey and certification process for health facilities participating in Medicare and Medicaid.

These organizations have reiterated the concern which led them to sign a similar statement in March prior to receiving assurances from you that you would not "imperil senior citizens in nursing homes, our most vulnerable population, by removing essential federal protections."

The endorsing organizations appeal to you to maintain your commitment to federal protections for nursing home residents.

Thank you for your consideration of these concerns.

Sincerely,

Elma L Griesel

Elma L. Griesel
Executive Director

ELG:mt

Enclosure

NCCNHR is a national, non-profit membership organization, founded in 1975, to improve the long-term care system and the quality of life for nursing home residents.

POSITION STATEMENT

RE: HCFA NPRM May 27, 1982 Medicare and Medicaid; Survey and Certification of Health Care Facilities

July 12, 1982

We, the undersigned, urge the Department of Health and Human Services to maintain its leadership and fulfill its responsibilities in working to assure a high quality of care and life for America's 1.3 million nursing home residents.

We maintain that the federal government should continue to operate an effective enforcement system that ensures, at least, minimum standards of care and decency by providing financial support and regulatory guidance to state agencies.

We were reassured by the commitment Secretary Schweiker made to the American public on March 22, 1982, when he stated, "I will not imperil senior citizens in nursing homes, our most vulnerable population, by removing essential federal protections. I will not turn back the clock."

It is our belief that the rule changes proposed by the Department of Health and Human Services on May 27 which would revise Subpart S - the survey and certification process - will, over time, imperil nursing home residents. We oppose the proposed regulations as a step backward and a removal of essential federal protections.

We agree that the survey and certification system needs improvement; therefore, we urge the Department to withdraw these proposed rules in favor of developing a new proposal which would focus the system on the actual quality of services received by residents. We stand ready to assist in the task of designing a system which effectively ensures high quality care and services.

Further, we urge the Department to seek essential funding to ensure that the federal and state systems have continued enforcement capability. State survey agencies have reported 30-40% cuts in program funds which have limited their ability to monitor nursing homes and other health care facilities. HHS regional oversight of state enforcement activities has also been significantly reduced by the budget cuts. Figures available through the Health Care Financing Administration indicate that $121 million is needed in FY 1983 to carry out a viable survey and certification program. While this represents far less than 1% of the funds expended for nursing home care by the government, it is money which helps assure that billions of health care dollars are well spent.

We call upon the Department to withdraw these regulatory and budgetary proposals which endanger essential protections for nursing home residents.

National Organizations Endorsing Statement

American Association of University Women
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Jewish Congress
American Public Health Association
Association for the Advancement of Psychology
Center for Community Change
Coalition of Labor Union Women
Commission on Social Action of Reform Judaism
Committee on Aging, Unitarian Universalist Association
Consumer Coalition for Health
Consumer Federation of America
Council of Jewish Federations
Episcopal Church Center
International Association of Fire Chiefs
National Alliance for the Mentally Ill
National Association of Activity Professionals
National Association of Area Agencies on Aging
National Association of Health Facility Licensure and Certification Directors
National Association of the Physically Handicapped
National Association of Retired Federal Employees
National Association of Social Workers
National Caucus and Center on Black Aged
National Citizens' Coalition for Nursing Home Reform
National Coalition of Resident Councils
National Community Action Agency Executive Directors Association
National Conference on Catholic Charities
National Conference on Social Welfare
National Council of Jewish Women
National Council of Senior Citizens
National Council on the Aging
National Farmers Union
National Gray Panthers
National Mental Health Association
National Women's Health Network
Older Women's League
Service Employees International Union
United Auto Workers
United Church of Christ
Urban Elderly Coalition
Women's Equity Action League

Office of Legislative Affairs, Women's Division, General Board of Global Ministries, United Methodist Church
Washington Office, United Presbyterian Church in the U.S.A.

Separate listing of state and local organizations and individuals on next page.

State and Local Organizations and Individuals Endorsing the Statement

In addition to the 96 state and local organizations which NCCNHR represents (and which are included in the attached list), the following organizations and individuals have endorsed this statement:

Bentley Gardens Resident Council, New Haven, Ct.
Harbor View Manor Resident Council, New Haven, Ct.
Federation of Jewish Philanthropies of New York
Task Force on Health and Human Services of the Episcopal Diocese of Connecticut
Commission on Aging, Ohio
Commission on Aging, District of Columbia
Office on Aging, District of Columbia
Long Term Care Council, National Association of Social Workers, Calif.
Senior Issues Action Committee, Nashville Communities Organized for Progress, Tenn.
Coalition for Improved Long Term Care of Arizona Valley of the Sun Gray Panthers
Gray Panthers of Metropolitan Washington, D.C.
Montana Seniors' Advocacy Assistance
Elderly Law Project, New Haven Legal Assistance, Ct.
Attorneys for Plaintiffs and Plaintiffs in Intervention in Smith V. O'Halloran
Long Term Care Ombudsman Committee, District II, Fla.
Nursing Home Ombudsman Program, State of North Carolina
Sarah Greene Burger, R.N.
Elma Wolf, L.C.S.W., A.C.S.W.

NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

MEMBER ORGANIZATIONS - July, 1982

California
Berkeley Gray Panthers, Berkeley
Citizens for Better Nursing Home Care, Oakland
Citizens for Better Nursing Home Care, Soquel
Citizens Who Care, Davis
Concerned Citizens for Better Nursing Home Care, Monterey
Gray Panthers of Santa Clara County, San Jose
Nursing Home Ombudsman Program, San Francisco
Ombudsman, Inc., Riverside
Sacramento Area Long Term Care Ombudsman, Sacramento
Santa Barbara Citizens for Better Nursing Home Care, Santa Barbara
Senior Adults Legal Assistance, Palo Alto
Sonoma County Ombudsman, Sabastopol
United Neighbors in Action, Oakland

Colorado
Concerned Relatives and Friends of Residents of Nursing Homes, Ft. Collins
Family and Friends of Nursing Home Residents, Aurora
Nursing Home Review Committee Advisory Board, Pueblo

Connecticut
Connecticut Citizens Concerned with Convalescent Care, Cromwell

District of Columbia
Washington Home Residents Council, Washington, D.C.

Florida
Citizens Advocates Community Group, Pensacola
Nursing Home Hotline Patrol, St. Petersburg

Georgia
Long Term Care Facility Ombudsman, Douglasville
Long Term Care Ombudsman Program, Valdosta
Nursing Home Ombudsman Program of Metropolitan Atlanta, Atlanta
Nursing Home Ombudsman Project, Brunswick

Illinois
Committee for Community Involvement in Nursing Homes, Champaign
Illinois Citizens for Better Care, Chicago

Indiana
Byron Health Care Residents Council, Fort Wayne
Legal Services Organization of Indiana, Indianapolis
United Senior Action, Indianapolis
Volunteers Organized to Assist in the Institutionalized Care
of the Elderly and Sick, Evansville

Kentucky
Citizens Involvement Project, Louisville

Louisiana
Citizens for Quality Nursing Home Care, New Orleans
State Nursing Home Ombudsman Program, Baton Rouge

(continued)

Maine
Maine Comaittee on Aging

Maryland
Maryland Advocates for the Aging, Baltimore
Maryland Conference of Social Concern, Baltimore
Montgomery County Ombudsman Program, Wheaton
Nursing Home Ombudsman Program, Salisbury

Massachusetts
Age Center of Worcester Area, Worcester
Cambridge and Somerville Legal Services, Cambridge
Cape Cod Nursing Home Council, Hyannis
Central Massachusetts Legal Services, Worcester
Consumer Advocates for Better Care, Leominster
Cooperative Metropolitan Ministries, Newton
Greater Boston Elderly Legal Services, Boston
Nursing Home Advocacy and Assistance Project, Holyoke
Nursing Home Ombudsman Program, Fall River
Unitarian Universalist Committee on Aging, Boston

Michigan
Citizens for Better Care, Big Rapids
Citizens for Better Care, Detroit
Citizens for Better Care, Farmington
Citizens for Better Care, Flint
Citizens for Better Care, Grand Rapids
Citizens for Better Care, Lansing
Citizens for Better Care, Metropolitan Detroit
Citizens for Better Care, Traverse City

Minnesota
Friends and Relatives of Nursing Home Residents, Minneapolis
Minnesota Senior Federation, Long Term Care Committee, Edina
Nursing Home Residents' Advisory Council, Minneapolis
Nursing Home Residents' Advocates, Minneapolis
Senior Citizen Coalition, Duluth
South Minnesota Legal Services

Mississippi
Jackson Gray Panthers, Jackson

Missouri
Kansas City Gray Panthers, Kansas City
Nursing Home Ombudsman Program, St. Louis

Nebraska
Mayors Advisory Committee on the Handicapped

New York
Coalition of Institutionalized Aged and Disabled, Bronx
Friends and Relatives of Institutionalized Aged, New York
New York City Nursing Home Ombudsman Program, New York
New York State Coalition for Improved Long Term Care, Albany
Relatives Association, Daughters of Jacob Geriatric Center, Bronx
State Communities Aid Association, New York
Village Nursing Home, New York

(continued)

Ohio
Nursing Home Ombudsman Program, Cleveland
Nursing Home Ombudsman Program, Dayton
Pro Seniors, Inc., Cincinnati

Oregon
Northwest Portland Gray Panthers
Oregon Legal Services, Portland
Salem Gray Panthers, Salem

Pennsylvania
Coalition of Advocates for the Rights of the Infirm Elderly, Phila.
Interfaith Friends, Scranton
Interfaith Friends, Wilkes-Barre
National Gray Panthers, Phila.
Northwest Interfaith Movement, Phila.

Rhode Island
Citizens Alliance for Nursing Home Residents, Cumberland
RIsource, Providence

Tennessee
Social Action Group on Aging, Nashville

Texas
Texans for the Improvement of Nursing Homes

Virginia
Friends and Relatives of Nursing Home Residents, Annandale
Friends and Relatives of Nursing Home Residents, Richmond

West Virginia
Center for Long Term Care Advocacy, Charleston

Washington
Citizens for the Improvement of Nursing Homes, Spokane
King County Coalition of Nursing Home Resident Councils, Seattle

Wyoming
Advocates for Care of Elderly, Laramie
Concerned Citizens for Quality Care, Casper

RESPONSES FROM NEW JERSEY SURVEYORS TO NCCNHR SURVEY

Current survey sytem:

* "Many patients get quality care; many get caring care. Less than a majority get competent and caring care."
* "The present system adequately evaluates the quality of care in good facilities that keep good records. It does not adequately evaluate the quality of care in good facilities that keep poor records or in mediocre to poor facilities that keep good records."

Current level of nursing home care:

* "Most nursing home patients do not receive the rehabilitative services that they need including physical therapy, occupational therapy, speech therapy, or the dental services, opthomological services, andrological services and prosthetic devices and braces."
* "Most physical plans are in acceptable condition. Most fire safety standards are met. Education is needed to stop propping open of fire doors which is very common. In addition a few older facilities are open with waivers which would appear to allow hazardous situations to continue forever. There should be time limits to structural waivers."

Annual inspections:

* "Probably 20-30% of nursing homes would maintain standards without annual inspections. The majority would not. They would cut costs by reducing staff and services. Some providers also use outside inspections to motivate staff to maintain standards of care. The health department has conducted periodic abbreviated weekend surveys, totally unknown to the facilities. Findings included no nurse, no R.N., staff shortages, altered meal hours, shortages of linens, supplies in approximately 40-50% of the homes visited, to varying degrees. Indicates the need for periodic monitoring."

Suggestions for improvements:

* "I would design a survey based on an audit of care given based on established guidelines of care for each diagnosis, combining diagnoses as necessary. Criteria for the care of patients with diabetes, CHF, ASHD, hip fracture, malnutrition, etc. would be established and compliance reviewed."
* "The survey process should be less concerned with the policies and procedures and a little more conscious of the condition of the patients during the survey, and the overall outcomes of the patient's care over time, as found in the medical record."
* "The two processes (medical review and certification) should probably be combined, however, two different types of views of the facilities' operation are being determined by these two processes. Perhaps the two survey groups could be combined and do combined surveys. Thus if the group doing the medical review finds a weakness in one phase of several patients treatment the group doing the survey could be alerted to determine if there is a problem in the department providing the service and vice versa."
* "Major ingredient is providing sufficient direct care personnel, both licensed and ancillary, to meet the physical needs of clients. Nurses and aides working on a ratio of 1 to 8 and higher are overworked and frustrated because they cannot give the type of care they want to and subsequently leave nursing."
* "Increase the number and competence of the aide employed in these facilities. They are the first line of defense. If they are incompetent, unfeeling, or short-staffed, the nurses feel overworked and become less caring and so on."

Our Questions About Their Answers: A Response to HCFA & JCAH

1. In response to our concerns about the survey cycle, HCFA maintains that no home will be allowed to continue with life-threatening deficiencies and that 20% of all nursing homes are currently "superior."

WE ASK:

- Must an individual suffer to the point that her life is endangered before HCFA is concerned? We refer you to the comments of the resident from New York quoted on Page 7 of our testimony.
- How does HCFA rank quality of life on the scale of deficiencies deserving serious scrutiny?
- How can these home be considered "superior" merely because they meet the basic minimal standards to which they agreed when they voluntarily signed the provider contract?
- Since HCFA's computer system is based on "key elements" of compliance, does this mean that the current regulations, in total, are not taken into full consideration when determinations of compliance, and of the survey cycle are made? Isn't this de facto rule-making, without the benefit of public input?

2. HCFA discounts the need for an on-site visit to verify the correction of deficiencies in cases where a problem is corrected on the spot, where the problem will take a longer period of time to correct, and where it is only a trivial matter involving documentation. It uses as examples the unlocked narcotics cabinet, the missing nurse, the missing documentation that a function has bee performed.

WE ASK:

- Could the deficiency which is corrected on the spot recur? Could it be symptomatic of more serious problems?
- Could the missing documentation mean that the service was not provided?
- Can't revisits regarding problems needing a long period of time to fix evaluate the progress the facility has made, and in fact, help ensure progress?

3. HCFA maintains that it has requested from Congress increased survey funds in the form of a reprogramming of the current budget to take funds from audits, and that the proposals are not based on budget constraints.

WE ASK:

- If the administration truly has a commitment to effective oversight of nursing home care, why would it trade audit money for survey money? Will the administration request the additional funds needed to provide a budget of $121.2 million for survey activities?
- Why has the administration in fact allowed many of the changes it is now proposing for public comment to take place already in many states through waivers based on budget constraints?

4. HCFA states that the JCAH has verbally agreed to change the way it handles life threatening conditions it encounters, by notifying the state agencies, and to improve its Life Safety Code component.

WE ASK:

- What guarantee do we have that JCAH would make these changes? What public involvement is there in the development of JCAH's survey procedures? If JCAH is allowed to perform under its own procedures isn't this also de facto rule-making? Why do we bother to discuss proposed changes in Subpart S?

5. JCAH points to the GAO report of 1979 as evidence that it has a laudable survey process for hospitals and as justification for extention of this process to nursing homes?

WE ASK:

- Since, at the time of the report, only 5 states accepted deemed status for JCAH accredited hospitals, what proof do we have that the system functions well now that over 30 states are using the JCAH? Has it ever been tested in nursing homes?
- The GAO report praised the JCAH for its uniformity of surveys and for the specificity of its standards. Yet in 1981 JCAH, in response to requests

the American Medical Association and the American Hospital Association, developed issue papers discussing changes in their procedures to apply flexibility and variety and to relax the specificity of the standards. Why would the JCAH change the very aspects of its process which the GAO commended?

6. The JCAH says that the fact that it has a public member and representation on its advisory boards by a consumer organization proves that it is accountable to the public.

WE ASK:

- Who is this public member? How is he selected? What does he do to represent the public?
- How does the JCAH solicit public comment and incorporate those comments into its decision making process?
- Doesn't the fact that it will not breach its confidential relationship with the facility suggest that it feels more responsibility to the facility than to the public?

7. JCAH maintains that it does have an adequate complaint investigation system?

WE ASK:

- How many complaints does JCAH receive? How many does it investigate on-site?
- What are its complaint investigation procedures? What is the timeframe for its investigations? How does it protect the confidentiality of the complainant?

Mr. FLORIO. Thank you very much.
Ms. Wright?

STATEMENT OF BARBARA W. WRIGHT

Ms. WRIGHT. Thank you very much, Congressman Florio, and also for the opportunity to offer testimony on the proposed changes to the enforcemnt provisions for Federal nursing home regulations.

Dr. Germain was unable to be here today, so I represent the director. I am Barbara Wright, executive director.

As nurses, we have a unique opportunity both to be witness to and advocate for adequate care in nursing homes. The geriatric nurse practitioner, a new specialist, is particularly qualified to advocate for professional health care for the elderly.

We agree that nursing home care is improving in many institutions and is excellent in those of high quality. However, in the marginal and poor quality nursing homes the standard of care is of major concern to us. Since solutions to the problems of elderly care have been initiated, we urge you not to relax the standards that have corrected some of the nightmares experienced by some elderly patients.

Annual inspections and mandatory 90-day resurveys are essential to prevent a series of problems that can quickly overwhelm a nursing home. Without regular surveillance, excellent standards of care can deteriorate to unsafe and dangerous care. If the numbers of dietary aides are reduced, the systematic feeding of patients unable to feed themselves may be overlooked, resulting in nutritional problems that could weaken already infirm individuals. A simple fiscal decision to reduce the number of chux or disposable pads ordered can result in wet beds, followed by bedsores. If problem patients tax an overworked staff, excessive sedation may be administered. These problems can turn a good, safe nursing home into a very unhealthy place to live.

The regulation which requires submission of staffing reports is a necessary mechanism to maintain safe and adequate care. Without such reports, in a time of severe economic constraints, adequate numbers of nursing staff may not be employed. Professional nurses are charged with the planning, implementing and evaluating of the patient's care. The nurse as well as the administrator is accountable to the consumer, the State, and the public to insure that proper and quality care is being rendered. The licensed nurse is the patient's best assurance that an adequate standard of care will be provided. The number of skilled nursing hours offers one measure, although only one, of quality of care; therefore, we urge continuation of staffing reports. The question of who shall regulate the nurses' workplace and the patient's living place is also of concern to us.

The proposal to modify requirements for State agency surveys in institutions which choose to have JCAH accreditation requires much greater study than we have had time to complete. Rather than overhaul the entire system, we recommend that a pilot sample of institutions participate in an alternative method of evaluation. Further change in the regulations could be based on such experience. Historically JCAH accreditation has not contributed to

cost containment in care for acutely ill patients and may not serve to streamline health care facility approval procedures for them.

In summary, the New Jersey State Nurses' Association supports annual governmental inspections and 90-day resurveys of nursing homes. We support quarterly reports for staffing and very seriously oppose any relaxation of the above standards.

We would appreciate the opportunity to answer questions after the panel is completed.

Mr. FLORIO. Thank you very much.

Ms. Shainwald?

STATEMENT OF SYBIL SHAINWALD

Ms. SHAINWALD. I am Sybil Shainwald of the National Women's Health Network. We have 10,000 individual members and 300 organizational members representing a constituency of approximately 500,000 women.

The network appreciates this opportunity to testify again to the proposed changes in nursing home surveillance and wishes to express its thanks to Congressman Florio for inviting us, and to Congressman Hughes, and to give our views on a major health issue.

One of the network's vital concerns is the health of those least capable of speaking out for themselves. And this includes the elderly in nursing homes. Women represent the vast majority of the nursing home population in the approximately 18,000 to 20,000 facilities. They are the main providers and consumers of nursing home care. As a national organization representing many of these women we must add our voice of protest to the proposed regulatory revisions and Federal budget cuts. We believe they would have a serious and harmful effect on the quality of care and safety of residents. We are therefore opposed to all of the changes in the surveys and certifications requirements.

Let us look backward for a moment to a year when an estimated 350,000 Americans were being cared for in nursing homes with an additional 250,000 in related facilities. Two-thirds were women. Only half could walk, even with the aid of a cane or crutches. The conditions as reported by Consumers Union in a major report was shocking. Homes where people were undernourished, maltreated, ill-kempt, neglected, who didn't leave their rooms, using chemicals and drugs as straitjackets. The year was 1964.

Why look backwards? Because we cannot afford to go back, not 1 inch and not 1 step. The National Women's Health Network agrees with the 46 Members of the House of Representatives including 11 Republicans who recently protested what they called a major shift and serious abdication of responsiblity on the part of the Federal Government after learning of Secretary Schweicker's proposals.

We believe the suggested revisions would only serve to weaken existing standards and procedures for enforcing those standards. They will do nothing to those who need protection the most, the poor and the elderly. They will not benefit nursing home residents. They will not benefit those of us with family members in nursing homes. They will not benefit the citizens of New Jersey. They will not benefit the women of this country or the men. They will not benefit the taxpayers. They will not benefit the American people.

For the 1.3 million residents of nursing homes the proposals represent an open invitation to abuses on the part of nursing home owners, the only special interest group who they will benefit.

We oppose all the proposed revisions. In particular the network must express deep concern to dropping the requirements that State agencies perform annual inspections and that nursing homes with problems be reinspected within 90 days. The Schweicker proposal to eliminate the mandatory reinspection is totally unsatisfactory. The nursing home industry has only recently overcome its sordid record of exploitation and only strong State and Federal regulations curb the greed of those who profit but lack willingness to give proper health care. In the name of efficiency and flexibility we will return to an easing of standards in the industry.

The proposal to insure correction of deficiencies by telephone calls or letters is woefully inadequate and hardly protects the residents of those homes sufficiently. We all know nursing homes correct conditions when threatened with the cancellation of their prior agreement. The new proposals require followup visits only if there is no other way to verify correction of the deficiency. If the money is cut isn't there always another way? Are we interested in saving paper or in saving lives? States will not be able to request money for resurveys if this is not federally mandated. We urge you to retain this protection.

The monitoring process has already been eroded. Out of 29 States responding to a recent questionnaire, 17 reported that they conduct surveys less frequently due to shrinking dollars. One State indicated it is starting to conduct inspections by sampling residents. And one State only responds immediately to those complaints which are—we wonder who makes those decisions. Is this what we want for the elderly? Is this what we want for ourselves?

The network believes we need more, not fewer inspections. The focus should be on the nursing home resident, not on the nursing home owner. We are concerned with the quality of care being given to individuals. The proposed regulations do nothing to address the main problems of the system but instead serve to dilute consumer protection. They take away and give nothing in return.

The Federal Government spends billions of dollars each year on nursing homes. More than half of the revenue comes from tax dollars. In return the Government has attached conditions to the money it pays. The survey costs are less than 1 percent of the funds expended. This is a small price indeed for a large responsibility. The National Women's Health Network urges Congress to insure that monitoring is kept at least at current levels.

If the Congress wants to know the truth about nursing home conditions in the future, if other agencies want information, if the public wants to know, where will it come from? We are all aware of the fact that the nursing home residents are often the least able to testify as to their care and treatment and sometimes out of fear of reprisals. For this reason alone the network believes it is essential not to leave any nursing home unmonitored for 2 years, even for the 20 percent of homes that the Health Care Financing Administration believes would qualify it for this cycle. Since the average length of stay for an occupant is 2 years, some residents whose average age is 85 years might be in totally uninspected homes.

Residents conditions and nursing homes facilities change too rapidly to allow this to occur. Shrinking medical dollars have already cost the quality of care according to State agencies—it is necessary that nursing homes be as open to the outside as possible. It is vital that there be a frequent presence in nursing homes, whether it be a friend, a family member, or a surveyor. The surveying requirement insures a minimum presence at least once a year and it is particularly important when we realize visits are often infrequent and residents often do not have families. The surveying requirement is required. The Congress must be mindful that there is no other or better way of insuring that the elderly and infirm receive the care mandated by law.

Finally, the National Women's Health Network opposes the authorization of field status recertification by a private nongovernmental nonregulatory body, JCAH. We oppose this on many grounds, as 26 of the 29 States responding to a recent questionnaire. JCAH has no enforcement capability and limited complaint ability. There is only 1 public member out of 22 with major control resting in the American Medical Association and the American Hospital Association. Thus there is neither significant consumer representation nor public accountability. Moreover, JCAH has expressly declined to become a regulatory agency. The States would still have to be staffed and ready to intervene in problem situations if they are to fulfill their responsibilities. Why not continue to pay them?

Further, JCAH does not have the same standards for accreditation as the Federal Government and we oppose any changes in the standards. Moreover, JCAH itself is in the process of revising its own standards, a process that takes place without consumer input, unlike the Federal process.

This portion of the proposed revisions has an additional danger of curtailing information available on nursing homes. JCAH surveys are confidential and specifically exempt from disclosure requirements. Posting current reports at a facility is woefully inadequate. How will we be able to look at the records of nursing homes over the years? Will we have to go to Chicago, JCAH's only location? Even then what will we have access to?

JCAH surveys may be viewed as an option by States to save money, but it is an option with no positive value for nursing home residents. It will only make the monitoring process more difficult for concerned citizens and concerned Congress people.

The so-called flexible regulations that have been proposed would serve to release the industry from its essential minimal standards. Washington now pays the States to perform annual inspections and verify that violations are eliminated. Secretary Schweicker has described nursing home residents as our most vulnerable population. There is no justification for relaxation of supervision at this time.

While the survey and certification system may need improvement, the National Women's Health Network does not believe the present proposals meet that goal in any way. We therefore urge the Department to withdraw its proposed rules and develop realistic ones which would focus on the quality of care received by residents. We further urge the Secretary to consult with other consum-

er groups such as the National Senior Citizens Law Center to design a system which would assure this.

All of us have an interest in improving nursing homes. Many of us have close relatives in nursing homes. As aging citizens, some of us will need nursing home care for months or for years. As taxpayers, all of us are helping to pay the costs of nursing home care.

We all have a major stake in getting our money's worth in terms of health care and tax dollars. The present proposals are not the answer.

Thank you.

Mr. FLORIO. Thank you very much. I appreciate the testimony from all three of the witnesses. An insight as we go forward deals with the initiative of what has been labeled regulatory reform. This is an effort to review regulations, to curb some of the abuses of the regulatory system which have been uncovered over the years, I think it is very important that we evalaute regulatory systems to see that they are achieving the goals that they are supposed to achieve, rather than just make dismantling decisions in accordance with budgetary constraints.

Another aspect of this, particularly in light of our next panel, is that the regulated community has a vested interest in regulatory certainty. If we are going to, in an arbitrary way, start the process of dismantling regulations, not only does it have an adverse impact upon, in this case, the patients in nursing homes, it is going to have an adverse impact upon the legitimate, good, regulated community. We are going to find that the only beneficiaries are those who are not willing to comply and that the good regulated community operators will pay a price by virtue of badly regulated operators being able to take advantage of the gaps in the system. So I think that is a very important point. I think much of your testimony has reinforced that point.

Congressman Hughes.

Mr. HUGHES. I have no questions. I think you have done an excellent job in identifying the issues and raising the questions we have to ask and expressing our great concerns over the proposal. I am indebted to you. Thank you.

Mr. FLORIO. Thank you very much. I appreciate your help.

Before calling our next and last panel, I would just like to acknowledge the presence in the audience of our nursing home ombudsman volunteer from here in Camden. Gertrude Koerner has submitted for the record a statement. It will be placed in the official record of the hearing. Likewise, anyone else that desires to submit testimony for the record, please feel free to submit it to us either today or to my office, or Congressman Hughes' office. We will be sure it is made a part of the official record of these hearings.

Our last panel of witnesses is made up of Mr. Paul Mullen, director of Government Relations, Joint Commission on Accreditation of Hospitals; Mr. James Cunningham, president of the New Jersey Association of Health Care Facilities; and Dennis Hett, executive director of New Jersey Association of Non-Profit Homes for the Aging.

Gentlemen, we welcome you to the committee. We appreciate your attendance here today.

Perhaps Mr. Mullen, it would be appropriate for you to go forward first.

STATEMENTS OF PAUL MULLEN, DIRECTOR, GOVERNMENT RELATIONS, JOINT COMMISSION ON ACCREDITATION OF HOSPITALS; JAMES E. CUNNINGHAM, PRESIDENT, NEW JERSEY ASSOCIATION OF HEALTH CARE FACILITIES, AND DENNIS R. HETT, EXECUTIVE DIRECTOR, NEW JERSEY ASSOCIATION OF NONPROFIT HOMES FOR THE AGING

Mr. MULLEN. Mr. Chairman, Mr. Hughes, I am Paul E. Mullen, director of government relations for the Joint Commission on Accreditation of Hospitals. I am pleased to have the opportunity to present the views of the joint commission on the administration's proposals to modify the medicare/medicaid provider survey and certification process. Considering the historic roles of the JCAH in the area of quality assurance and as a component of the medicare/medicaid certification system, we believe it particularly appropriate that our views on these issues be included in the record of these proceedings.

We have provided a copy of our prepared statement. Therefore, in the interest of brevity, I will omit the portion dealing with our history and proceed to that portion which deals specifically with the subject of these hearings and covers the matter of JCAH recognition in abbreviated form. If you don't mind, at the end I will try to address, ad lib the questions that the previous panel addressed specifically to the joint commission.

Mr. FLORIO. All right.

Mr. MULLEN. I would like to say that this is our 65th year, as well. On May 27 the Department of Health and Human Services proposed to accept JCAH accreditation in lieu of a State survey for skilled nursing facilities and hospital-based home health agencies, that participate only in the medicare program. The Department further proposes to allow State agencies the latitude of according similar recognition of JCAH accredited skilled nursing facilities, hospital based home health agencies, and intermediate care facilities which participate in medicare and medicaid or in medicaid only. The preconditions to the above described recognition are that the facilities post the JCAH accreditation report and be subject to a medicare/medicaid validation and complaint survey process.

Since there are reported to be about 320 skilled nursing facilities which participate in medicare only and no hospital based home health agencies which participate in medicare only, these regulations mean that 320 facilities in the Nation would be allowed to seek JCAH accreditation and if successful, to use evidence of such accreditation as an avenue for obtaining medicare certification providing they agree to post JCAH survey comments and recommendations, and subject themselves to medicare validation and complaint surveys.

As an aside, I have heard two persuasive arguments today which suggest the States are unlikely to exercise the option described, the first case being if it represents a notion that less funds are coming, that seems to me to be a disincentive to accept that option. If there

are indeed substantial cuts in the medicare/medicaid financing program, it seems that creates a significant disincentive for institutions to spend the money for accreditation, because it is likely they would not fully recover such costs in the reimbursement process.

As we understand it, this automatic recognition would not apply to the more than 17,000 skilled nursing facilities and intermediater care facilities or the 474 hospital based home health agencies which participate in medicaid. We understand, of course, that State agencies might choose to relay on JCAH accreditation in whole or in part as a part of their medicare and medicaid certification activities, subject to the preconditions outlined above. As we interpret this enabling authority a State agency might recognize accreditation as satisfying a part of its survey responsibility for a given medicare/medicaid standard or its survey responsibility on alternating years, or for selected good facilities only, or any combination of the foregoing.

As far as we can tell none of the 1,300 long-term care facilities or 600 hospital based home health agencies we presently accredit would be immediately affected by these proposed regulations because we believe they all participate in the medicare and medicaid, in medicaid only, or in neither program.

We are aware that many publics are particularly critical of the accord of medicare deemed status to hospital based HHA's and SNF's accredited by the JCAH. We wish to take this opportunity to address some of the issues which have been raised with respect to this matter.

Some critics suggest that the fact that JCAH must rely on survey fees for its viability represents a built-in conflict of interest, that is, JCAH is reluctant to render a nonaccreditation decision because such a decision results in a loss of business. To this we would submit that the fact that JCAH regularly makes nonaccreditation decisions with respect to facilities/programs seeking accreditation clearly demonstrates a JCAH commitment to make accreditation decisions which are inimical to its own financial interest. While we believe that only those facilities which believe they can meet JCAH standards apply for accreditation, we also believe we must apply our standards rigorously if we are to remain a credible accrediting organization.

You might find it interesting to compare the frequency with which the Federal Government makes medicare/medicaid decertification, or a State which makes a delicensure decision, with the record of the joint commission.

Some publics allege that the JCAH accrediation process is insufficiently sensitive to the concerns of the publics served by the facility/program seeking accreditation and that unlike federally financed inspections, JCAH does not follow up on adverse survey findings or perform complaint investigations. We submit that facilities/programs seeking accreditation are required to post public notice of an impending survey and of the opportunity for a public information interview with the survey team and JCAH surveyors are instructed to interview patients concerning the quality of their care. The JCAH does follow up on adverse survey findings and the JCAH does perform complaint investigations.

It is also, I think, important to digress just a moment here. If we understand the statute correctly, there is, it seems to us, an implied absolute obligation on the part of the Federal Government in connection with the deeming, that the Federal Government, if it decides to deem is obliged to conduct not only sample surveys of those deemed facilities, but complaint investigations of them as well. So it suggests to me that the use of JCAH accreditation, if it were used, sets up two avenues the patient has for complaint. One to the Federal Government, which has an absolute requirement to investigate, second, a Joint Commission avenue which also has a requirement to investigate.

It has been suggested that the annual reports to Congress on the medicare validation surveys are uniformly unfavorable to the JCAH; hence provide persuasive evidence of the inappropriateness of extending current medicare recognition of accredited hospitals and certainly to the extension of this recognition to accredited long-term care facilities. It is our view that it is inaccurate to characterize these reports to Congress as being uniformly unfavorable to the JCAH.

In the conclusion of all these reports, the Secretary has continued to recommend that the DHHS continue to rely on JCAH accreditation. The reports have highlighted the differences between JCAH and State agency surveyor findings in the Life Safety Code area, but also noted the use of differing codes (1967 version for HCFA vs. 1973 version by JCAH) and the fact that the use of differing standards and differing team compositions are likely to produce differing findings.

The results of the GAO report suggest JCAH is a credible evaluator. In addition, there is another GAO report which hasn't been mentioned which points out the fact that hospitals are probably the safest institutions in the country. Some might make the case that because of the reliance on JCAH accreditation for purposes of medicare/medicaid certification that JCAH is in part responsible for that fine record of hospitals.

Some have characterized the JCAH survey process as merely a review of resources, hence a process underserving of recognition by the department. We wish to make it clear that although our accreditation has always involved an assessment of whether a hospital or long-term care facility had adequate resources—nurse staffing for example—it has also always focused on process and outcome as well. Effective infection control programs, tissue review functions, professional staff credentialing mechanisms and adequate life safety code adherence, for example, have long been integral to the JCAH accreditation process.

The Department's proposal to recognize JCAH accredited SNF's for medicare certification purposes has been criticized on the basis that JCAH has neither consumer representation nor public accountability. To this, we would respond that the JCAH has consumer representation on its Board of Commissioners, on its Policy Advisory Committee, and on its Long-Term Care Professional and Technical Advisory Committee.

Further, it is not clear that the JCAH has no public accountability. The annual report to Congress on the results of the validation

survey of JCAH accredited hospitals represents a very high standard of public accountability.

In addition, the JCAH accreditation process has been subjected to an examination of the U.S. General Accounting Office—the investigative arm of Congress—and we would submit this is a form of public accountability.

The JCAH accreditation process involves a requirement that the facilities/programs we survey for accreditation post public notice of our impending survey and of the availability of a public information interview with our surveyor staff.

Finally, we believe our practice of investigating complaints from the public about institutions we accredit attests to the fact that we behave in a fashion consistent with the concept of public accountability. We will furnish you a report of the number of complaint investigations in the past 2 years.

[The following information was subsequently received:]

Over the past twenty-four months the JCAH long-term care accreditation program has received approximately 24 complaints about facilities we accredit. As a result of these complaints we have conducted eight unannounced out of cycle on-site investigations. Some of these complaints are from facility management and pertain to the quality of our survey and surveyor performance. All complaints pertaining to the quality of patient care were investigated through the unannounced visit, correspondence, a regularly scheduled visit and/or a combination of all of the foregoing.

Mr. MULLEN. In conclusion, we believe the Department's proposal insofar as it addresses the Joint Commission is entirely consistent with the Secretary's authority as outlined in the Social Security Act. We believe these regulations provide a historic opportunity to enhance the quality of care in long-term care facilities in this country, an opportunity to bring the long-term care community into the mainstream of high quality health care in this Nation.

The program of negative incentives has been imposed on the long-term care community since the advent of medicare. This has undoubtedly brought about significant improvements. There has been all kinds of testimony about that today on both sides. In our view, the Secretary is now suggesting a "carrot and stick" approach to the achievement of quality long-term care. He has not only suggested mechanisms State agencies might use to reward consistent excellence, but also a means of concentrating oversight on those facilities most in need of it.

State agencies, under these proposals, will be able to husband their resources and engage in novel and imaginative initiatives designed to bring about positive change.

Mr. Chairman, I wish to thank you for this opportunity to express the views of the JCAH on these important issues. This concludes my prepared remarks. At this time, I would be pleased to answer any questions or furnish any other information members of the committee may request.

The question was raised, what is our standard setting process? We provide draft copies of our proposed standards to all who ask. We are in the process of revising those accreditation program standards and have mailed out copies of those proposals for comment to over 3,300 addressees. We go about evaluating them in much the same fashion as the Federal Government, National Fire Protection Association, and others.

Review and comment, the Standards and Surveys Procedures Committee of the board is given a matrix showing the proposed standards, the support for it, the opposition to it, the changes made or not made, and the reason why. The recommendations go back. More often than not, as a result of that first process, the standards are sent out again for a second review to everyone who commented the first time. That sometimes goes on, the drafts are numbered alphabetically. Sometimes that goes through as many drafts as J.

There was a question about who were the public members. I think it is fair to say it would be impossible for us to satisfy everybody who claimed to be a public representative. Mr. William Mitchell, president of the Central Telephone and Utilities Corp. of Illinois is on our board. The American Association of Retired Persons is on the Professional, Technical Advisory Committee to our long term care program. Mr. John Iglehart, a well-known writer on health issues in this country, is on the Policy Advisory Committee to the board.

The New Jersey Nurses Association pointed out the Joint Commission has not been pointed to as an example of how the health care facilities could spend less. I think that is very fair criticism. For example, in the long-term care standards, we require a licensed registered nurse on every shift. The medicare/medicaid conditions do not, so that facilities wishing to seek our accreditation would clearly have to spend more money than those who do not.

Thank you very much for this opportunity.

[The prepared statement of Mr. Mullen follows:]

STATEMENT OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS ON THE PROPOSED CHANGES TO THE MEDICARE/MEDICAID PROVIDER SURVEY/CERTIFICATION PROCESS

Mr. Chairmen, I am Paul E. Mullen, Director of Government Relations for the Joint Commission on Accreditation of Hospitals (JCAH). I am pleased to have the opportunity to present the views of the Joint Commission on the Administration's proposals to modify the Medicare/Medicaid provider survey and certification process. Considering the historic roles of the JCAH in the area of quality assurance and as a component of the Medicare/Medicaid hospital certification system, we believe it particularly appropriate that our views on these issues be included in the record of these proceedings.

JCAH/HISTORICAL BACKGROUND

Before addressing myself to the subject of these hearings, I would like to present background information about the JCAH. In 1951 the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association (which withdrew in 1959 to participate in its own national hospital accreditation program) joined with the American College of Surgeons to form the Joint Commission on Accreditation of Hospitals. The JCAH was incorporated as a not-for-profit corporation.

In 1981 the American Dental Association became a member organization of the JCAH and in 1982 a public member, Mr. William D. Mitchell, President, Central Telephone and Utilities corporation of Chicago, Illinois was added to our Board of Commissioners.

In addition to its Hospital Accreditation Program, the JCAH also establishes standards and offers voluntary accreditation programs throughout the United States for adult psychiatric facilities, children's and adolescent's psychiatric facilities, drug abuse treatment and rehabilitation programs, alcoholism treatment and rehabilitation programs, community mental health services, long term care facilities and ambulatory health care organizations. Collectively, the accreditation programs of the Joint Commission survey over 4,500 facilities, services, and programs in the course of a year, and approximately 7,300 facilities, services and programs currently

hold JCAH accreditation. Represented in this statistic are over 70 percent of the hospitals in the United States.

The JCAH standards for hospital accreditation as contained in the Accreditation Manual for Hospitals, 1982 edition, have a long history of development. The first "Mimimum Standard for Hospitals" was issued by the American College of Surgeons (ACS) in 1917. During the following 35 years, ACS conducted a Hospital Standardization Program which caused a natural evolution in hospital standards. In 1952 when the JCAH survey program was implemented, these minimum standards of the ACS program were utilized.

The adopted minimum standards were revised six times by the JCAH Board of Commissioners between 1953 and 1965. Then in August 1966, the Board of Commissioners voted "to review, re-evaluate, and rewrite the hospital accreditation standards and their supplemental interpretations to raise and strengthen the standards from a level of minimum essential to the level of optimal achievable and to assure their suitability to the modern state of the art."

Consequently, the standards underwent extensive revision, resulting in the 1970 edition, called, for the first time, the Accreditation Manual for Hospitals (AMH).

Since then, the Manual has undergone continuous review and revision to keep abreast of the state of the art including the incorporation of standards for hospital-based home health services.

LONG-TERM CARE ACCREDITATION PROGRAM STANDARDS

The JCAH adopted a code of standards for extended care facilities in October 1965 and inaugurated an accreditation program in this area the following January. The program standards have been subject to continuous change with major changes in 1967, culminating in entirely new accreditation manuals in 1975 and 1979. Major reviews of our long term care nursing and social services standards are presently underway. There are currently approximately 1,300 long term care facilities in the nation which are accredited by the JCAH; nearly 600 of these are integral to hospital.

JCAH INVOLVEMENT WITH GOVERNMENT

In the years prior to 1965, the JCAH was the nation's chief standard setting organization for hospital medical care. With Congressional enactment of Medicare the federal investment in hospital care rose dramatically. Included within the 1965 amendment to the Social Security Act was the provision that the Department (then DHEW) certify that institutional providers (including hospitals, extended care facilities and home health agencies) desirous of functioning as Medicare providers meet certain health and safety standards. Although modeled after the then current JCAH voluntary requirements, these federal conditions of participation signaled the beginning of federal involvement in standards setting activity in health care facilities.

The 1965 amendment established a special relationship between Medicare and the JCAH hospital accreditation program. Under section 1865 of the Act an institution accredited as a hospital by the JCAH was considered or "deemed" to meet most of the certification requirements of Medicare, essentially giving it automatic eligibility to participate in the Medicare program.

Hospitals that did not choose to be accredited by the JCAH were surveyed by the Department which contracted with state agencies to apply the Medicare conditions of participation in these hospitals, and to make certification recommendations to the Secretary.

In 1970 a suit was brought by a consumer group against the Department and the JCAH in which it has alleged that Congress had unconstitutionally delegated legislative authority to the JCAH, a private organization, i.e. the power to determine conditions for Medicare participation. Eventually, Senate hearings were held on this issue resulting in enactment of Section 244, Pub. L. 92-603, which authorized the Secretary to set standards for Medicare participation higher than those adopted by JCAH, to conduct validation and complaint surveys, and to make an annual report to Congreess on the results of such surveys. The suit was subsequently dismissed.

Section 1865 of the Act not only stipulated that JCAH accredited hospitals would generally be considered as meeting the statutory requirements for Medicare participation but also contained language enabling the Secretary to rely on the accreditation process of any (emphasis added) national accreditation body which provides reasonable assurance that one or more of the conditions of participation for hospitals, skilled nursing facilities and home health agencies are met for purposes of Medicare certification. This brings us to a consideration of the issues being addressed by these hearings.

THE DEPARTMENT PROPOSAL

On May 27, 1982 the Department of Health and Human Services (Dhhs) proposed to accept JCAH accreditation in lieu of a State survey for skilled nursing facilities and hospital-based home health agencies, that participate only in the Medicare program. The Department further proposes to allow State agencies the latitude of according similar recognition to JCAH accredited skilled nursing facilities, hospital-based home health agencies, and intermediate care facilities which participate in Medicare and Medicaid or in Medicaid only. The preconditions to the above described recognition are that the facilities post the JCAH accreditation report and be subject to a Medicare/Medicaid validation and complaint survey process.

Since there are reported to be about 320 skilled nursing facilities which participate in Medicare only and no hospital-based home health agencies which participate in Medicare only these regulations mean that 320 facilities in the nation would be allowed to seek JCAH accreditation and if successful to use evidence of such accreditation as an avenue for obtaining Medicare certification providing they agree to post JCAH survey comments and recommendations and subject themselves to Medicare validation and complaint surveys. As we understand it this automatic recognition would not apply to the more than 17,000 skilled nursing facilities and intermediate care facilities or the 474 hospital-based home health agencies which participate in Medicaid. We understand, of course, that State agencies might choose to rely on JCAH accreditation in whole or in part as a part of their Medicare and Medicaid certification activities, subject to the preconditions outlined above. As we interpret this enabling authority a State agency might recognize accreditation as satisfying a part of its survey responsibility for a given Medicare/Medicaid standard or its survey responsibility on alternating years, or for selected "good" facilities only, or any combination of the foregoing.

As far as we can tell none of the 1,300 long term care facilities or 600 hospital-based home health agencies we presently accredit would be immediately affected by these proposed regulations because we believe they all participate in Medicare and Medicaid, in Medicaid only, or in neither program.

We are aware that many publics are particularly critical of the accord of Medicare "deemed status" to hospital based HHAs and SNFs accredited by the JCAH. We wish to take this opportunity to address some of the issues which have been raised with respect to this matter.

CONFLICT OF INTEREST

Some critics suggest that the fact that JCAH must rely on survey fees for its viability represents a built-in conflict of interest, i.e. JCAH is reluctant to render a nonaccreditation decision because such a decision results in a loss of business. To this we would submit that the fact that JCAH regularly makes nonaccreditation decisions with respect to facilities/programs seeking accreditation clearly demonstrates a JCAH commitment to make accreditation decisions which are inimical to its own financial interest. While we believe that only those facilities which believe they can meet JCAH standards apply for accreditation we also believe we must apply our standards rigorously if we are to remain a credible accrediting organization.

PUBLIC RESPONSIBILITY

Some publics allege that the JCAH accreditation process is insufficiently sensitive to the concerns of the publics served by the facility/program seeking accreditation and that unlike the Federally financed inspections JCAH does not follow up on adverse survey findings or perform complaint investigations. We submit that facilities/programs seeking accreditation are required to post public notice of an impending survey and of the opportunity for a public information interview with the survey team and JCAH surveyors are instructed to interview patients concerning the quality of their care. The JCAH does follow up on adverse survey findings and the JCAH does perform complaint investigations ranging from letters of inquiry to unannounced on site surveys.

JCAH AS A CREDIBLE EVALUATOR

It has been suggested by some that the annual reports to Congress on the Medicare validation surveys are uniformly unfavorable to the JCAH; hence provide persuasive evidence of the inappropriateness of current Medicare recognition of accredited hospitals and certainly to the extension of this recognition to accredited long term care facilities. It is our view that it is inaccurate to characterize these reports

to Congress as being uniformly unfavorable to the JCAH. In the conclusion of all these reports the Secretary has continued to recommend that the DHHS continue to rely on JCAH accreditation. The reports have highlighted the differences between JCAH and State Agency surveyor findings in the Life Safety Code area but also noted the use of differing codes (1967 version for HCFA vs. 1973 version by HCAH) and the fact that the use of differing standards and differing team compositions are likely to produce differing findings. A complete review of this subject is contained in U.S. GAO report HRD #79-37, May 14, 1979, and this review may be characterized as being supportive of the Department's proposed extension of recognition of accreditation.

Some have characterized the JCHA survey process as merely a "review of resources"; hence a process undeserving of recognition by the Department. We wish to make it clear that although our accreditation has always involved an assessment of whether a hospital or long term care facility had adequate resources, nurse staffing for example, it has also always focused on process and outcome as well. Effective infection control programs, tissue review functions, professional staff credentialing mechanisms and adequate life safety code adherence, for example have long been integral to the JCAH accreditation process.

PUBLIC ACCOUNTABILITY

The Department's proposal to recognize JCAH accredited SNFs for Medicare certification purposes has been criticized on the basis that JCAH has neither consumer representation nor public accountability. To this we would respond that the JCAH has consumer representation on its Board of Commissioners, on its Policy Advisory Committee and on its Long Term Care Professional and Technical Advisory Committee. Further it is not clear that the JCAH has no public accountability. The annual report to Congress on the results of the validation survey of JCAH accredited hospitals represents a very high standard of public accountability. In addition the JCAH accreditation process has been subjected to an examination of the U.S. General Accounting Office, the investigative arm of Congress, and we would submit this is a form of public accountability. The JCAH accreditation process involves a requirement that the facilities/programs we survey for accreditation post public notice of our impending survey and of the availability of a public information interview with our surveyor staff. Finally, we believe our practice of investigating complaints from the public about institutions we accredit attests to the fact that we behave in a fashion consistent with the concept of public accountability.

Finally we have heard that it has been alleged that a recent review conducted by New York State shows that there are several JCAH accredited nursing homes that have been found severely deficient by state inspectors and that this circumstance argues against the Department's proposed recognition of accreditation. We have contacted officials of the New York State Agency to obtain the results of this review. They deny knowledge of such a review; hence the meanings of the terms "several" and "severely deficient" are not clear and it is further unclear that the alleged review was made. If such a review was conducted and deficiencies were found in JCAH accredited long term care facilities it is likely that the reviewer made a value judgement that such problems were severe. At the same time it is equally likely that JCAH found these same problems, that they may or may not have been characterized as severe and the facility's accreditation may or may not be contingent upon timely correction of these problems subject to verification by JCAH surveyors. It is important to note that JCAH accreditation does not mean that a facility/program has no deficiencies. In fact, the JCAH has yet to discover that facility/program meeting all our standards. It is also important to note that unless a program/facility is appropriately licensed by the State Agency it is ineligible for JCAH accreditation.

You have asked that we address at least three additional questions. I will attempt to do so.

FEDERAL AND STATE RESPONSIBILITIES FOR HEALTH AND SAFETY IN LONG TERM CARE FACILITIES

It is our view that States are responsible for protecting the health and safety of all their citizens including those who are patients or residents in long term care facilities. States typically exercise this responsibility through licensure statutes and regulations. The Federal government has a responsibility to act to protect citizen health and safety with respect to activities involved in interstate commerce. This responsibility is frequently exercised through Federal licensure statutes and regulations, for example interstate licensure of clinical laboratories. The Federal govern-

ment also has a responsibility for exercising prudence in the expenditure of public revenues, for example the establishment of minimum specifications for items or services to be purchased with Federal funds. The conditions of participation for Medicare/Medicaid are an illustration of Federal activity in this area and in this regard the Federal government has historically contracted with State agencies to inspect Medicare/Medicaid providers to insure that the medical care product being purchased meets the Federal minimum standards.

EFFECT OF PROPOSED REGULATIONS AND DECREASING FEDERAL FUNDS ON THE MEDICARE/MEDICAID SURVEY AND CERTIFICATION PROCESS

It is entirely fitting and proper that this subject be addressed as two separate issues. The affects of reductions in Federal funding of the Medicare/Medicaid survey and certification process are not clear, and are at least influenced by both their magnitude and application. As we understand it there are no Federal standards for the composition of State Medicare/Madicaid inspection teams or for the length of such inspections; hence there is great variability from State to State. One might imagine a scenario wherein standardization of this process was effected in a fashion whereby no reductions were effected in some States (those which historically had followed the adopted Federal standard) and at the same time significant reductions were effected in other States, i.e. those with large survey teams spending longer periods in inspections. Another scenario, of course, is one in which a uniform percentage reduction is effected in each State. In this situation the State which only performed marginally in the past could only be expected to perform more marginally in the future. Another scenario might involve a reduction of funding of such signancing of Medicare/Medicaid certification activity to finance State licensure activity and are unwilling to assume State financing of this State function, inadequate viders. As you know Section 2153 of Pub. L. 98-35 (The Omnibus Budget Reconciliation Act of 1981) amended the Social Security Act in a fashion designed to allow the Secretary to make Medicare/Medicaid inspections of Skilled Nursing Facilities (SNFs) less frequently than once a year. We believe the legislative history of that amendment makes it clear the Congressional intent that the Secretary avail himself of this authority and institute a biennial inspection cycle. If this is indeed the case, it might be inferred that Congress intended the Federal financing for this inspection activity be reduced by one-half as well.

In summary it is not clear whether a reduction in Federal financing in and of itself will have any effect on the health, safety and comfort of nursing home patients; it could, as we have pointed out, have the effect of achieving more uniform and equitable oversight over long term care providers than has been the case heretofore . . . it might also have the affect of reducing overall Federal oversight, even to unacceptable levels in some States. If States have relied heavily on Federal financing of Medicare/Medciad certification activity to finance State licensure activity and are unwilling to assume State fiancing of this State function, inadequate oversight over the health and safety of long term care patients may result. With respect to the other half of this issue, that is, the affect of the proposed regulations of the health, safety and comfort of nursing home residents, we see no intrinsic dire consequences. The elimination of the absolute requirement for the quarterly staffing reports does not mean that States wishing to continue this mechanism may not do so. There has been conflicting testimony from State agencies concerning the use fulness of the report; quite frankly we believe there is no substitute for on site examination of payroll and time sheet information to establish compliance with minimum standards.

The proposed rules would obviate the mandatory automatic 90-day resurvey requirement. We believe this represents a triumph of reason over rote. Some problems need to be corrected immediately others may take longer and may be less important. The idea that State agencies would be allowed to exercise judgement in this regard is certainly intellectually attractive. The critics of the proposed elimination of time-limited agreements have pointed to the salutory affects of the "spring house cleaning" syndrome which affects facilities preparing for inspection, the variability in quality from year to year, and the impact of facility management and staff changes as persuasive evidence of the need to perpetuate 12-month time-limited agreements with their associated certification inspections. Unquestionably these arguments have merit; however the central issue is how much oversight is enough. We believe the instant proposal strikes a reasonable balance, provides State Agencies with unlimited regulatory latitude and for the first time creates an incentive for providers to excel. If we understand this proposal correctly providers consistently obtaining excellent inspection results could be subject to fewer inspections.

PUBLIC ACCOUNTABILITY

Your last question seems to be whether the proposed rules represent an abandonment by the Federal government of its public accountability to assure that minimum Federal standards are being met with respect to the provision of care reimbursed with Federal funds. We believe the changes being proposed are entirely consistent with Section 1865 of the Social Security Act; Section 244, Pub. L. 92-603; Section 2153, Pub. L. 97-35 (The Omnibus Budget Reconciliation Act of 1981); and Pub. L. 96-354 (Regulatory Flexibility Act of 1980). It seems clear that the proposed rules return a great deal of authority of States and we believe some could make a case that this course of action was originally contemplated in Section 1864 of the Social Security Act. We do not believe the proposed changes in and of themselves represent an abandonment of public accountability by the Department.

CONCLUSIONS

In conclusion Mr. Chairman, we believe the Department's proposal in so far as it addresses the JCAH is entirely consistent with the Secretary's authority as outlined in Section 1865 of the Social Security Act. We believe, however, that the recognition proposed is insufficiently broad. The Department has spent over four years reviewing the JCAH standards and survey process with respect to hospital-based home health services and two years in the examination of our accreditation process for long term care facilities. In both instances we have been advised of the Secretarial finding that our accreditation process provides reasonable assurance that skilled nursing facilities and hospital-based home health agencies we accredit meet the Medicare conditions of participation. Considering these findings we believe the Secretary should have proposed that skilled nursing facilities and hospital-based home health agencies accredited by JCAH which participate in Medicare and Medicaid be exempt from separate Federal certification surveys performed by State agencies. Such a proposal would have enabled up to 4,423 skilled nursing facilities (which participate in both Medicare and Medicaid) to seek JCAH accreditation and if successful to automatically use such accreditation as a vehicle for obtaining their Medicare/Medicaid provider certification. We also believe such a change would enable the 474 hospital-based home health agencies we presently accredit to use this accreditation in lieu of their present separate state agency certification survey as an avenue to Medicare and Medicaid certification and thus eliminate this duplicate activity.

We believe these regulations provide a historic opportunity to enhance the quality of care in long term care facilities in this country; an opportunity to bring the long term care community into the mainstream of high quality health care in this nation. A program of negative incentives has been imposed on the long term care community since the advent of Medicare. This program has undoubtedly wrought significant improvements, however we believe the maximum benefits of this "stick" approach have been reached. In our view the Secretary is now suggesting a "carrot and stick" approach to the achievement of quality long term care. He has not only suggested mechanisms State agencies might use to reward consistent excellence but also a means of concentrating oversight on those facilities most in need of it. State agencies, under these proposals will be able to husband their resources and engage in novel and imaginative initiatives designed to bring about positive change.

Mr. Chairman, I wish to thank you for this opportunity to express the views of the JCAH on these important issues. This concludes my prepared remarks. At this time, I would be pleased to answer any questions or furnish any other information members of the Committee may request.

Mr. FLORIO. Thank you very much.

Mr. Cunningham.

STATEMENT OF JAMES CUNNINGHAM

Mr. CUNNINGHAM. Thank you, Mr. Chairman.

I assume this invitation results from my letter of June 28 to members of New Jersey's congressional delegation in which we generally endorsed these proposals. I have attached a copy of that letter. You will note that our support was based on the results of a successful pilot program conducted by the Federal Government and the State department of health. Apparently this program has not

been brought to the attention of any of the people who have testified today, because I haven't heard it mentioned at all. As I go into the testimony further, you might find it a very viable middle of the road negotiable settlement between Secretary Schweiker's proposal and what currently is in the rest of the country, but was not in New Jersey at the time of this pilot for that year.

My letter also indicates that the changes have roots, not only in the present Federal administration, but also in the Carter administration's "Operation Common Sense," designed to reduce waste and inefficiency in the Federal Government.

Specifically, you asked me to respond to three questions:

Question 1. What are the appropriate Federal and state agency responsibilities in insuring nursing home standard compliance?

Answer. The basic responsibility of the Federal Government should be to establish strong minimum standards which can be further improved by the State governments. For example, New Jersey traditionally has enforced higher standards than those required by the medicaid and medicare program. To avoid duplication, State inspection teams should assure that these standards are observed. This is not to preclude spot checks by Federal agencies, general review of inspection documents by HHS, or other methods to assure the highest level of protection to nursing home patients.

Question 2. How would the proposed Federal regulations and decreasing Federal funds for the survey and certification process affect the health, safety, and comfort of nursing home residents?

Answer. We think the changes would improve standards throughout the long term care field. We assume that the facilities excepted from the annual inspection requirement would be proved to be clearly superior. Since there is less money available for survey and certification in the new budget, the inspection teams will be able to better allocate resources by concentrating on those facilities which have been shown to need upgrading.

Mr. FLORIO. Assuming we know what those facilities are, how are we to knowledgeably target at the state level, monies to ascertain if we are using our limited resources in the most cost effective way?

Mr. CUNNINGHAM. In the pilot study that was done. The Federal and state governments cooperatively together determined the standards of excellence, types and numbers of deficiencies allowable not only over a 1 year period of time, but over the last few years of the records of those facilities, then so designated the exceptional facilities. They will be the only ones to undergo the lesser inspection. It was not an every 2 year inspection, as you will see in my testimony. They still went in every year. But they didn't do the four to six person team, 2 or 3 day type of thing where they looked at every piece of paper, every policy.

Half the problems in previous years with surveys is they fail to look at the patients. That is the name of the game. That is what are in our places, patients. You could have a paperwork palace and come out great, but you might not have the greatest care. In this type of lesser survey that the exceptional facilities do, they send their full team in. But they do a walkthrough, smell, look at the patients, instead of doing all the paperwork stuff which takes them

a couple of days, then they determine that the situation has not changed there, and that is the end of the survey.

We do think this type of system that was piloted here would work. It is not identical to Secretary Schweiker's proposal. It still gives an annual, but lesser in exceptional type facilities and they are very easily determined, even though they are not very easily determined by numbers of deficiencies, much to our chagrin, and the States—actually one of the quirks mandated by the Federal Government causes greater numbers than might actually be in that facility.

The Federal Government, as you know, has its skilled criteria, its ICF criteria and they also have their ICFMR criteria. Now, that makes it possible for a facility to be cited deficient in like 790 some odd areas. But the quirk it causes is that the Federal Government mandates that the State cite that facility on a deficiency no matter how many times it appears in the manual. There could be a very minor deficiency in a facility that appears five or six times in the various manuals and that place is cited five or six times like they had five or six deficiencies. So it gives them a little problem in looking at the exceptional. You may have an exceptional facility with 10 or 12 deficiencies, and they may be basically no problem.

With the present fiscal constraints and without changes somewhat like those proposed by Secretary Schweiker, surveyors will be able to make fewer repeat visits to those nursing homes that require upgrading. Such reallocation of the inspection force was a clear success in the New Jersey pilot project which excepted 59 superior facilities from the full force inspections for a short walk through on an annual basis. Instead of a formal inspection by four or six surveyors for a period of 2 to 3 days, the same teams conducted a brief survey lasting no more than a half-day.

Perhaps this short, periodic review might bridge the gap between Secretary Schweiker's proposals and the existing Federal regulations.

Question 3. How would the proposed rulemaking affect the public accountability that nursing homes are meeting standards in the fullest possible extent?

Answer. We think there would be no diminution in the public accountability, particularly if the walkthrough modification that I recited above is incorporated with the rule changes.

Most of the comments I have heard from a lot of other people today inferred that the facilities that need help and need work would not be done annually. This proposal does not say that. Those facilities not only would be done adequately, they could be done four or five times. In New Jersey that happened. There were times that they would go into some facilities every week, or every other week, to make sure that the things that needed to be done were done.

When you can have that kind of concentration on your lesser facilities, it is going to have to improve the lives of the patients who happen to be in that facility.

Mr. FLORIO. I don't know if you heard Mr. Fay this morning say that the superior facility, however defined, can deteriorate fairly rapidly within the course of a year. If one didn't get to the superior facility within 1 year, concentrating one's resources and efforts on

others assumed to be less high quality, one would never get around to having walkthrough surveys and other kinds of surveys and wouldn't know the facility had deteriorated over the period of a year.

Your suggestion about what has come out of the demonstration project in terms of how to get more out of the survey may very well make a lot of sense and we would like to look into that a little bit more. But the heart of the proposed regulations will effectively preclude us having walkthrough surveys or any other kind of surveys because it is not going to be required. That, combined with the lessoned amount of resources at the State level, it seems to me, inevitably is going to have some places uninspected, where we wouldn't know if they meet quality standards, old or new ones that may be proposed.

Mr. CUNNINGHAM. You will have several other forces at work here. As you are well aware, you heard from the Essex County people who are in the facilities. The patients, those themselves in the facilities. If you know the ombudsman law you know his poster is on every one of the bulletin boards. The department of health posters and their hotline must be posted on every one of the bulletin boards in there.

We have no objections to those kinds of procedures, we think they are very essential and necessary to the total system, because we don't want bad places either. They rub off on all the places and it is no benefit of ours to have places that are going to give the industry a black eye. But when you look at the exceptional facilities, I am sure, and many of them talked today about the cutback of funds going to facilities, medicare/medicaid doesn't pay all the costs of those facilities. If you fill your house with them you are going to be bankrupt. In order to attract a private pay market who is going to spend their money in the place, you can't be running a dump. If you have got an exceptional facility of this type you can be assured that the predominance of those in that category need a decent private pay clientel to offset the insufficient Government payments.

Mr. HUGHES. Do you put medicare and medicaid in the same category?

Mr. CUNNINGHAM. Yes, I do.

Mr. HUGHES. Reimbursement is the same?

Mr. CUNNINGHAM. No, it is not identical in New Jersey. In some States it is, but in New Jersey it is not identical. There are certain costs not allowable in both systems. Medicare is a little different than medicaid in this State as far as screened areas. You can lose money. Neither pays all the costs.

Mr. HUGHES. Let me back up just a minute. As I understand it even HHS agrees that there should be a mandated inspection every 2 years.

Mr. CUNNINGHAM. Right.

Mr. HUGHES. So there is an understanding that it has served notice on operators that there was going to be an inspection regardless.

Mr. CUNNINGHAM. We agree any inspection should be unannounced.

Mr. HUGHES. Even though the program in New Jersey was successful, the fact of the matter is that our department of health agrees that the 1 year inspection requirement is essential.

Mr. CUNNINGHAM. Well, you should have dealt heavier with that because that was discussed with me by the same people who sat here today.

Mr. HUGHES. That was their testimony.

Mr. CUNNINGHAM. What they are saying, they would like to have the study back. That is a 1 year. They want it in the exceptional facility, still to be able to go into the place with that facility having the full knowledge that they are going to be in there during the course of the year, but they want to do this less type survey by exception in the facilities that they deemed exceptional.

Mr. HUGHES. You are not suggesting that the 1-year inspection requirements do not have a positive impact upon homes, are you? I mean the fact that a nursing home is going to be inspected within 1 year, you are not suggesting that that doesn't have some positive impact on those operators to make sure they are diligent?

Mr. CUNNINGHAM. Any inspection would have an impact. It depends on what you call exceptional. We have facilities that would be in that category for their own self-respect, for their own capture of their clientel, for their own community relations, where they ever came——

Mr. HUGHES. You will concede, will you not, that some operators are going to slip?

Mr. CUNNINGHAM. We are not antisurvey. We are prosurvey.

Mr. HUGHES. No, no. The fact of the matter is that in these times of economic difficulty when operators have difficulties like everybody else, it is conceivable that care is going to slip. The only question is how long you let it go. We are recommending that possibly this moving to the State pilot project which proved very successful in the State, be done. That would give you—it leaves off the exceptional facility and leaves off staff time to spend time in facilities that need upgrading.

Mr. CUNNINGHAM. I can tell you as an association we assisted in that. I personally, along with the association interceded in facilities to assist the State in upgrading places where they were going to go after a license revocation. Some testified it takes too long for a license revocation. That is not a problem in New Jersey. A law was passed and we fully agreed with it that that State when they go in there can put a bed hold on that place before they leave. That means no new admissions in that place until whatever is necessary to be corrected is corrected. That is sort of a financial incentive for quick action, and it is much better than a year or year and a half down the road license revocation proceeding because loss of every bed is a financial loss to them.

This State has the procedure that they don't have to wait for license revocation. They can put a bed hold in a facility before they leave. We would like this motivation. Two or three days looking at patients is a waste of funds. They should spend 2 or 3 days in a facility that has the kind of record that you are talking about in a concentrated effort to upgrade it. Then we can be sure there aren't any less than desirable facilities in the State. Why is one inspection a year adequate in a less than desirable place?

Mr. HUGHES. It is not. What we are saying is, however, the annual inspection at least assures us we are going to go into homes that have operated in exemplary fashion, too. Obviously HHS agrees there is some sense to that, a commonsense approach. Assure yourself that good facilities have not slipped.

Mr. CUNNINGHAM. I am sure they feel, though, that an excellent facility is going to do that kind of slipping. I have the same feeling. I still think a once a year walkthrough in an excellent facility in this manner would take care of it.

Mr. FLORIO. We would be happy to receive any information you have as to the results of this demonstration project. We will also inquire of the Department of Health, which you weren't aware of before, to receive from them their recommendations as well.

Mr. CUNNINGHAM. Possibly the reason it wasn't received today is my understanding that they don't have the records.

Mr. FLORIO. We will inquire about it.

Mr. CUNNINGHAM. Why the Federal Government didn't require it at the end of that pilot, I am not sure.

Mr. FLORIO. Thank you very much.

Mr. Hett, we must vacate the premises before too long. If you could summarize, we would appreciate it.

STATEMENT OF DENNIS R. HETT

Mr. HETT. I can do some condensing. Thank you, Mr. Chairman.

The New Jersey Association represents 76 nonprofit and voluntary facilities for the aged in the State. We care for approximately 9,000 people in everything ranging from independent housing for older people through adult day care and skilled nursing. The majority of our facilities offer more than one type of care.

Our sponsorship comes form religious, geographic, fraternal and ethnic communities and home standards are in direct responsibility to the sponsoring groups. We do support high standards of care in long-term care and our structure gives an additional buttress to quality of care, the community being present to advocate higher care.

The onslaught of Federal cutbacks have rekindled the longstanding controversy about how to assure acceptability in long term care facilities. Remembering the serious problems in the sixties and seventies, the public is wary of policy changes. We have seen this morning that backing down on standards would make it easier to thwart the intentions of the regulations. The advocacy of regulations, however, is contradicted toward public ambivalence in public spending, the rate of increase fueled by expanding need, new regulations and inflation.

We believe this challenges regulators as never before to seek maximum efficiency in the performance of their responsibility. We believe regulation improves the overall quality of the regulated industry by compelling the marginal provider to meet minimum standards and serving as a backstop should performance of heretofore good facilities fall to unacceptable levels. The proposed regulations must, therefore, be understood as addressing issues of management of the survey and certification process, such as efficient

use of survey time to assure violations of standards will be detected and remedies administered.

We believe that the process of looking at facilities that have good records on the same basis as those that have problems is an approach that offers only diminishing returns. You get a very small return for the amount of effort you put in there. We would support the compromise position of an interim annual inspection so long as that interim inspection is based on the important indicators of patient care addressed before, such as the condition of patients. By looking at them, by talking with them, by smelling the place, by tasting the food and by looking at some of the records. We believe that this would help keep the good provider on their toes.

Finally, I think we should look at one of the other areas that has been mentioned often before, and that is the fiscal element. The reimbursement of nursing homes in this status based on the achievement of minimum standards. The majority of facilities, if they are making minimum standards, are set as the standard on which homes are going to be reimbursed. The result is that reimbursement only encourages the achievement of minimum standards and indeed, the State has recently cut reimbursement for nursing that goes beyond the minimum standard by saying the facilities that go beyond it are essentially Cadillac facilities and if they want to do it, they can go look for money somewhere else. I submit this is a contradiction to the kind of nursing home care that we want to be looking for.

I will address some of these other points as I address the major specific elements of the proposal, and those are, first of all, mandatory 90-day resurvey. We believe that there should be some flexibility to go after the marginal provider here. The key word here is discretion. Perhaps the Federal Government should be instituting some criteria on which the facility—which the State could go a little beyond the 90-day resurvey. There are some that think that may take 4 months to correct. In that case, the State, under current regulations, would be required to make two visits. If there were criteria in place which stipulated which kinds of deficiencies could go a little longer and which deserved immediate attention, I think we would achieve the positive result of this without running the risk that has been raised as a potential problem by other speakers.

With regard to the time-limitation agreements and cancellation clause provisions, we believe some limitation has to be placed on the agreements. This is becoming more of my personal opinion as I have listened to other speakers. You do need to have a renewal process at some point, a review process to sit back and look at it. I think some middle ground might be possible here. The cancellation clause, it might be good to have some kind of an automatic cancellation, especially if it were based on the seriousness of the deficiency. Again, we must look at the intention of these changes and go for the serious problems.

On the flexible survey cycle, I think that the presence of State is useful to even a very good provider as a lever, if you will, for those employees, those departments that are having some problems. It does help. I would again repeat our position that a limited survey that goes for the major indicators is an important way to go about

this on an annual basis. It would leave the State freedom to allocate the time to the marginal facilities and to better serve them.

Finally, on the question of deemed status on accredited facilities, some compromise needs to be worked out here. We may be able to make some progress by looking at the Freedom of Information Act. And since the public has such an investment in long-term care facilities through the millions of dollars going into patient care, perhaps they should be asked to send copies of the reports into the State survey agencies so that the State could review them, so that the State would have another source of information. I realize that this is something that is going to take a great deal of study, but that it is one that is worth approaching.

[The prepared statement of Mr. Hett follows:]

PREPARED STATEMENT OF DENNIS R. HETT, EXECUTIVE DIRECTOR, NEW JERSEY ASSOCIATION OF NON-PROFIT HOMES FOR THE AGING

The New Jersey Association of Non-Profit Homes for the Aging represents 76 charitable and governmental homes across this state. Our members serve over 9,000 older people in and through independent and sheltered housing, residential health care, skilled nursing, adult day care and a variety of non-institutional services. The great majority of our members offer more than one of these basic services.

Non-profit homes spring from religious, fraternal, ethnic and geographic communities, and stand directly responsible to those communities to maintain high standards. For many non-profit homes, public regulation buttresses community standards, setting forth the minimum from which the non-profit home builds its higher standards.

We support high standards as a means to assure that well-being of the frail, vulnerable people who are patients in nursing homes, and believe that the proposed regulations address this task in a reasonable manner, and in context of the current environment.

The onslaught of deregulation and federal cutbacks has rekindled a longstanding controversy about how to assure acceptability in long term care facilities. Remembering the serious nursing home problems in the 1960's and 70's, the public is wary of policy changes that appear to back down on standards or make it easier for mal-intentioned operators to thwart the intention of the regulations. Witness the past winter's public outcry when HCFA was forced to shelve draft regulations that were perceived as a dilution of standards.

This adamancy on standards is, however, contradicted by a public ambivalence towards government spending at a rate of increase fueled by expanding need, new regulations and inflation. We believe that this challenges regulators as never before to seek maximum efficiency in the performance of their responsibility. Regulation improves the overall quality of a regulated industry by compelling marginal providers to meet minimum standards and serving as a backstop should the performance of heretofor-good facilities to fall to unacceptable levels. The proposed regulations must therefore be understood as addressing issues in management of the survey and certification process, such as the efficient use of surveyor time to assure that violations of standards will be detected and a remedy administered. We submit that the most productive deployment of resources is achieved when the survey agency concentrates on upgrading marginal facilities. To assure continuing compliance of facilities with good records, the agency should scrutinize only crucial indicators between more detailed inspections. The point of diminishing returns has been passed in the inspection of complying homes, and we believe that these proposals would, as a whole, better serve the public interest.

We thus view these proposals as potential refinements of the process of managing survey and certification process. Given the fiscal realities of inadequate funding for the process, government survey agencies must place greater confidence in the increasing competence of the field. Alongside the more stringent surveys of the past decade, greater professionalism has been a major force in the increasing quality of the proprietary and non-profit homes. In spite of inadequate reimbursement and shortages of available personnel, long term care has improved because of a commitment to service and a desire to respond to human needs.

Before addressing the specific proposals, we must speak to a final element in the long term care environment—the federal budget process. We take small comfort

that long term care has survived attempts at truly debilitating budget cuts, and are concerned by current proposed Medicaid reductions and Medicare proposals to shift costs to providers and consumers. We are committed to quality care, but cannot work miracles. Reduced funding will ultimately show its effects in reduced admissions, reduced quality of life within facilities and reduced capacity to meet standards. Budget cutting must not be masked as reform.

Speaking from that background, the New Jersey Association of Non-Profit Homes for the Aging makes the following comments on the May 27, 1982 proposed rules:

1. Consolidation of medicare and medicaid certification and survey provisions.—We concur with the proposal that a single set of procedural requirements will alleviate interpretation problems when identical requirements are phrased differently.

2. Quarterly staffing reports.—The regulations currently require all facilities to submit staffing reports routinely. HCFA proposes to modify the current policy by requiring staffing reports only when the state survey agency requests them because the facility has a history of staffing deficiencies or was found not to meet all staffing requirements during its most recent certification survey. However, all facilities would be required to have staffing information available when they are surveyed.

NJANPHA supports elimination of quarterly staffing reports as a step toward cost-effectiveness and administrative efficiency. The quality of patient care depends, in large part, on adequate staff to give care. But counting numbers of personnel is no measure of staff quality or quality of care. Further, mandatory reporting is often redundant, since quarterly reports duplicate time sheets required by the Labor Department and other governmental agencies.

We support on-site monitoring of staffing activities in marginal or deficient facilities. We believe the suggested revisions provide a useful compromise by requiring all homes to have staffing information available when they are surveyed. We do suggest one clarification: that a facility's usually-kept staffing information, such as time sheets and payroll records, be adequate to meet the requirement that staffing information be routinely available at the time of a survey.

3. Mandatory 90-day resurveys.—Currently, whenever a provider is certified on the basis of an acceptable plan of correction, the survey agency must conduct another site visit within 90 days to verify that corrective action has been taken or is progressing reasonable. HCFA proposes to eliminate this requirement in favor of a follow-up visit to be scheduled whenever the correction can be asessed most realistically and to permit follow-up by mail or telephone if the state deems on-site reinspection unnecessary to determine compliance.

We agree that if the planned time for correction is, for example, four months instead of three months, reinspection twice within that period can be mechanistic and costly to both the state and the home. However, some deficiencies, though not life-threatening, may be serious enough to warrant interim monitoring to ensure corrective action is progressing toward the completion date, but with an outside limit of no more than six months for on-site resurvey of facilities with less than exemplary records of compliance. The system should be structured so as not to lead to unjustified postponement of corrective action.

We suggest that the rules should spell out that follow-up by mail will be limited to specific items for which compliance is usually verified through documentation, be it minutes of a required meeting, a copy of personnel policies, etc. If a document can be mailed to a state agency, and therefore be proven to exist, it is a waste of time and money to require a surveyor to travel to the home for a reinspection. More to the point is that lack of documentation may be symptomatic of a larger problem the home is experiencing, in which case the state should work with the home to identify and remedy the problem.

4. Time limited agreements.—In 1981, Congress enacted Section 2153 or P.L. 97-35, removing the 12-month limit on agreements with skilled nursing facilities. The proposed rules would eliminate the present requirement that agreements with skilled nursing and intermediate care facilities be limited to a period not to exceed 12 months.

We support the concept, but suggest that clearly-defined, adequate termination provisions are needed if the provision is adopted.

5. Cancellation clause provisions.—The rules would eliminate a requirement that a provider agreement, accepted on the basis of a plan for correction of deficiencies, be automatically cancelled unless the deficiencies have been corrected by a predetermined date. Under the proposal, life-threatening deficiencies continue to be subject to immediate termination procedures.

With the latter assurance—that termination provisions are not precluded from use by states when warranted—we support this change.

We encourage HCFA to use the authority available under P.L. 96-499 to effect "intermediate sanctions," a series of graduated penalties, ultimately leading to decertification of a facility consistently found out of compliance with the regulation. This would permit state to tailor sanctions to fit the nature of deficiencies.

6. Flexible survey cycle.—The regulations would eliminate a requirement that all facilities be subject to annual surveys with the exception of intermediate care facilities for the mentally retarded. Instead, facilities would be surveyed as often as necessary to assure compliance, but at least every two years for long term care facilities.

We support the proposal as an alternative to the current system of treating compliant and marginal homes uniformly. The survey interval, if made public, would be a basis for comparison, further motivating facilities to upgrade care in order to be competitive. Potential savings in time and money spent on surveying homes provides the opportunity for states to do more consultation with facilities requiring assistance in order to reach an acceptable level of compliance.

HCFA has assured that facilities with a history of poor compliance will be surveyed more often than annually. We suggest that states be given specific criteria for determining the variable survey cycle, in order to assure that budget and workload constraints will not weigh too heavily in the state's determination and forestall claims of bias.

It bears repeating that, in our view, the most reasonable and effective recourse in the current period of economic downtown and scarce resources is to target resources where they are needed most. This proposed regulation attempts to do so.

7. Deemed status for SNFs, ICFs and HHAs accredited by the Joint Commission on Accreditation of Hospitals (JCAH).—Under current regulations, hospitals accredited by the JCAH may be deemed to meet the conditions of participation for Medicare and Medicaid. HCFA proposes to extend this provision to that survey agencies may accept JCAH accreditation for SNFs, ICFs, and hospital-based home health agencies without an additional state survey. As a condition of deemed status, the facility would be required to post its current JCAH report of the survey findings in a prominent place.

Our national association—The American Association of Homes for the Aging—has endorsed this proposal and pledged to continue efforts to improve the quality of the JCAH program by actively working to upgrade standards, improve the quality of surveys, enhance the professionalism of surveyors and participate, if requested in training of survey staff.

NJANPHA supports disclosure of JCAH findings, and we recommended that as a condition of deemed status, all facilities be required to submit copies of the survey report to the state agency in addition to posting the reports in a prominent place in the facility. Disclosure of the survey findings is warranted because of government's major investment, through Medicare and Medicaid funding, in the facilities that JCAH would accredit. We encourage HCFA to seek Freedom of Information Act clarification of obligations in this regard.

As a further step, the states should conduct validation surveys of JCAH-accredited facilities; including those that are marginally acceptable. To select these facilities, it will be necessary to review JCAH findings, thus our recommendation that long term care facilities authorize the release of JCAH survey findings and plans of correction to the appropriate government agency. Homes unwilling to make survey results public can forego deemed status and become subject to the state survey procedure.

Voluntary professional accreditation enriches the measure of a facility, and adds a greater sense of accomplishment to service delivery. With the appropriate safeguards, deemed status of accredited homes can enhance the care available to this state's long term care patients.

We appreciate the opportunity to speak before the Committee and hope that these amendments will result in greater assurance that our older and frail citizens have access to care and services of a high quality.

Thank you.

Mr. FLORIO. Might I ask the representative from JCAH if they would have any difficulty with a motivation of the law in making your records fall under the Freedom of Information Act coverage?

Mr. MULLEN. I think what I suggested before was it seemed clear to me that the proposed rules would allow States to require institutions wishing to use their accreditation as an avenue for their medicaid certification, not only to post a copy of the report on the wall

but also send a copy to the State agency. I think we would have great difficulty with the notion that you might wish to pass a law which would specify that we were subject to the freedom of information statutes which in and of itself would seem to turn us into a Federal agency.

Mr. FLORIO. In a sense, the reason for the regulations is to perform the responsibilities and functions currently being performed by a public body. So if you are going to assume those responsibilities and be reimbursed for them, what is it that is philosophically repugnant about being treated as a Federal agency for purpose of the Freedom of Information Act?

Mr. MULLEN. It is our view that you could not even do that. I think there was a case, as a matter of fact, in 1972 which alleged that the original Social Security Act had unconstitutionally delegated to a private agency the Federal powers. The powers to set the standards.

Mr. FLORIO. But the proposed regulations effectively empower you to have public responsibilities that are currently being performed by a public agency.

Mr. MULLEN. The reason why we would not wish that are two: If we could all agree in this room, which is doubtful, to define what the quality of care is, the minimum level that the Federal Government should accept to pay for care in a health facility, and we would go around the country and review facilities and rate them 1 to 10. We could find a lot of two's and we would conclude that we could accept that standard. Because you are interested in equity, you have got to treat everyone alike, the most the Federal Government or any government can do, it seems to us, is enforce that equitable standard. You can't hold one facility to a higher standard than another. Unlike the Joint Commission, we could choose, to set that standards level at eight. We would like to think we have. We only have to worry about equity for facilities which seek accreditation. We must treat them fairly. You have to treat everyone fairly. We only have to treat fairly the people who want us to look at them. I think you would destroy the nature of voluntary accreditation if something of that sort were done.

Mr. FLORIO. I acknowledge what you are saying, but I am not sure I agree. Let me just express my appreciation.

I think the presentations made by this panel are very reasoned and balanced. I appreciate the suggestion of midpoint motivations as opposed to outright support or opposition. I think some of the suggestions that have been made certainly are deserving of close scrutiny. My overriding observation is that there seems to be uniformity in feeling that annual inspections are desirable.

There is some suggestion that perhaps the nature of the inspection should be modified for those facilities that qualify as good facilities, based on some systemized analysis. Once that determination is made, then that would in some way trigger a less comprehensive analysis or evaluation than would be required for a facility that does not on its face qualify for that specialized lesser amount of inspection. I think that is certainly something that should be deserving evaluation.

Mr. HETT. Yes, in essence it would be measured with a yardstick or meterstick that does not have the millimeter calibrations on it, but only the larger divisions.

Let me say another advantage of that kind of survey would be a psychological boost to the facility, greater esprit de corps in it, and it would be very good for its public perception. Facilities might be more likely to compete for that so long as it was truly a meaningful exception to the rule.

Mr. FLORIO. Let me just acknowledge, I see a representative from the facility in Pitman that I suspect is probably——

Mr. HETT. In fact, Reverand McCarty is no——

Mr. FLORIO. I have been there and don't purport to be an expert or technical person, but as a layman who has been to a number of nursing homes that facility has to rank among one of the highest facilities. It is just a very perfectly run facility. If we had no other types of facilities there wouldn't be a problem here today. Unfortunately, that may very well not be the general rule.

Mr. CUNNINGHAM. I understand that this pilot that was completed in New Jersey is currently in progress in Massachusetts, and possible also New York. Our concern is how many times does the Federal Government have to test something before they realize it is good and use it?

Mr. FLORIO. The irony of that, of course, you have mentioned a couple of locations, all of which seem to be in the Northeast. The Northeast States are going to get their disproportionate share of reductions in medicare and medicaid. I think the concern over the years for national programs is that we not have one standard of health care or educational care or anything else for New Jersey and another standard for Mississippi. There has to be certain levels of care, if we are going to be a nation, that should go out to all of our citizens. Obviously, Congressman Hughes and myself are here as New Jersey Congressmen. We also happen to be U.S. Congressmen. Therefore, we are trying to evaluate the impact of these proposed regulations not only on our own State, but across the Nation and in other States that may not be as sensitive to the need for dealing with this particular problem as our own officials are.

So I think you can appreciate the fact that we are almost looking at the worst case scenario and trying to avoid those types of developments as well. But I do appreciate your participation today and I look forward particularly in terms of trying to locate this study, and your cooperation. We will feel free to reach out for your continued input in this process. Thank you very much, we appreciate your cooperation.

As I indicated at the outset of our comments, the record is open. If there are later submissions anyone cares to make, we would be happy to accept them and make them part of the record.

With that stated, the committee stands adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

Appendix

SHADY LANE HOME,
Clarksboro, N.J., July 14, 1982.

Hon. JAMES J. FLORIO,
Select Committee on Aging,
Washington, D.C.

DEAR MR. FLORIO, In response to your letter dated July 7, 1982 requesting the views of our residents in regard to the proposed changes to the enforcement provisions for federal nursing home regulations, a meeting with residents Ms. Mildred Jones and Ms. Louise Meyer and staff members, Mr. Joseph F. Varelli, superintendent and Ms. Barbara J. Morrison, social worker was held on July 12, 1982.

The following comments are those offered by Ms. Meyer and Ms. Jones addressing the issues stated in your letter. It is the view of these residents that the annual requirement for inspection of most nursing homes should remain in effect. The residents believe that such inspections are necessary for the proper upkeep and the assurance of safety.

In relation to the issue of re-inspections, it is agreed by the residents that there is no need for re-inspection. Once a report of citations is offered, it should be assumed that such will be corrected as soon as is possible by the nursing home staff and officials.

In understanding the need to reduce inspections, the residents offer an alternative to yearly inspections. In the event that a nursing home continues to display only a few number, or no citations perhaps it might be inspected every two years.

Ms. Jones and Ms. Meyer see the need for continued, required submission of quarterly staffing reports which detail the average number and types of personnel of the facility to assure adequate staffing of nursing homes.

The residents do not see the need for a substitution for state inspections through the accreditation, by the Joint Commission on Accreditation of Hospitals.

In general, the residents view both the state and federal roles of government as valuable to providing a safe and healthy living environment. It is agreed, however, that the state government is more aware of the needs and problems of nursing home residents.

We thank you for the opportunity to share our views with you.

Sincerely,

MS. LOUISE MEYER,
MS. MILDRED JONES.

SENIOR SERVICE CORPS.,
Orange, N.J., July 13, 1982.

Re HSQ-502-P: Subpart S—Proposed changes of Federal survey and certification procedures.

Congressman JAMES FLORIO,
Longworth House Office Bldg.,
Washington, D.C.

DEAR CONGRESSMAN FLORIO: The Board of Trustees of the Senior Service Corps, an agency which represents and serves over 40,000 older men and women in Essex County, New Jersey, is deeply concerned over the abdication of public responsibility to protect the health and safety of the 1.3 million infirm elderly institutionalized in our Nation's nursing homes.

We are concerned that the enforcement shift from government agencies to a private agency will invite cases of abuse. New proposals calling for a flexible survey cycle of up to 2 years, no mandatory resurvey when certification is based on a promise to correct deficiencies and use of announced visits by the certification agency,

will encourage deterioration of facilities and the ultimate neglect of a safe, sanitary, humane and dignified living environment for the residents.

The proposal to replace certification by State agencies with granting of "deemed status" to the Joint Commission on Accreditation of Hospitals, presents problems of possible conflict of interest as well as of public accountability. It is questionable that a system which provides the nursing home facility with advance notice of inspection by a private agency, JCAH, will result in proper and impartial inspections that would provide the kind of consumer protection that is intended by established nursing home regulations.

"Deemed status" also presents fiscal problems for State licensure agencies. States rely heavily on federal funds to operate licensure agencies which also serve to investigate complaints from nursing home residents and the general public. With "deemed status" for JCAH, State agencies, still responsible for enforcement of standards, would receive no funds for investigating complaints and enforcing standards for a JCAH accredited facility. In some States, this may be viewed as an option for saving money resulting in less public access to nursing home facilities, less redress of complaints and a return to the willful neglect and inhuman conditions that marred the nursing home industry in the recent past.

We therefore urge that the current nursing home regulations be kept in place and that enforcement of those regulations be strengthened. This can only be accomplished by a continuing government policy which demonstrates an unrelaxed commitment to monitor the quality of services to its institutionalized frail elderly.

We thank you for the opportunity to present our position and to express our concerns.

Very truly yours,

ELEANOR S. RUBIN,
President, Senior Service Corps.

NEW JERSEY HOSPITAL ASSOCIATION,
Princeton, N.J., July 27, 1982.

Hon. JAMES J. FLORIO,
Longworth House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE FLORIO: The Health Care Financing Administration in the Department of Health and Human Services has issued proposed rules simplifying and streamlining procedures by which hospitals and skilled nursing facilities, intermediate care facilities and hospital-based home health agencies would be approved for participation in Medicare and Medicaid. The long-awaited proposal represents HHS' first major deregulation initiative by aiming at elimination of unnecessary duplication of costly hospital regulations. Although progress has been made in recent years to coordinate the standards and surveys used for Medicare certification, state licensure and voluntary accreditation, the New Jersey Hospital Association believes that further revision of the Medicare certification program would reduce regulatory costs without jeopardizing health and safety.

Key provisions affecting hospitals, skilled nursing facilities (SNF), intermediate care facilities (ICF), and hospital-based home health agencies (HHA), include consolidation of Medicare and Medicaid surveys and certification regulations. Also, more flexible survey cycles have been added (hospitals at least every three years, SNF and ICF, and hospital-based facilities, at least every two years; and ICF for the mentally retarded at least annually), and deemed status would be granted for SNF and ICF, and hospital-based HHAs accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

The New Jersey Hospital Association, along with the American Hospital Association, supports these streamlining regulations proposed by the Department of Health and Human Services. There has been some negative reaction to these proposed rules due, in our judgment, to a misunderstanding of the impact they would have. It is important to note that a reduction in the number of inspections would only be granted to those facilities which have had an excellent record of compliance with the Joint Commission on Accreditation of Hospitals requirements in the past. We ask that you support these proposed rules, as they will help result in a cost sav-

ings to the health care industry with no harm to the health and safety of the patients involved.

Sincerely,

LOUIS P. SCIBETTA, F.A.C.H.A.,
President.

CAMDEN COUNTY OFFICE ON AGING,
Mt. Ephriam, N.J., July 16, 1982.

Good morning members of the committee, Ladies and Gentlemen: As an active Volunteer Ombudsman visiting a nursing home on a regular basis for the past 5½ years, I wholeheartedly concur with the statement of Ms. Rice, on behalf of the Camden County Office on Aging.

Eliminating annual inspections would definitely be a threat to the care and high standards that have been achieved by these inspections and regulations. Once more the elderly would develop a fear of nursing homes. Lets be careful that the light isn't taken out of the twilight years. I would like to add that the inspections would be more meaningful if advance notice weren't given of the time. The element of surprise would be much more effective with a definite follow-up.

Staffing reports are very, very necessary, especially at this time when we are trying to upgrade the geriatric standards of everyone coming into contact with Nursing Home residents. More geriatric training is a must.

I feel strongly that the high level of care that has been attained is due to the present regulations and any change would hurt the aged that are the grit that went into our country that makes it so great and enviable to other nations. Personally I have used "I might have to call Trenton", and it has worked wonders.

Respectfully submitted,

GERTRUDE KOERNER.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,
Trenton, N.J., August 9, 1982.

Hon. JAMES J. FLORIO,
First District, New Jersey,
Camden, N.J.

DEAR CONGRESSMAN FLORIO: Since you are co-chairman of the House Select Committee on Aging, I am forwarding for you information, a copy of my comments of July 23, 1982 on the proposed regulations on survey and certification of health facilities, HSQ-502-P.

There are basically two areas of the proposed regulations which I am supporting, the flexible survey cycle and the State's option of deeming JCAH accreditation. With reference to the flexible survey cycle, I do not agree that this will result in facilities becoming lax or that patients will be getting poorer care. I attempt to point out in my comments that Medicaid regulations governing Utilization Review and Inspections of Care are sufficiently prohibitive to prevent this from happening.

Likewise, I am supportive of the proposed deeming status on JCAH accreditation. As you know, such accreditation is acceptable under HCFA regulations for both Medicare and Medicaid participation with general hospital facilities. Along with all the internal control at the State level, there does not seem to be any valid reason why JCAH cannot also be utilized to determine the acceptability of long term care facilities for both Medicare and Medicaid approval. The key to this proposal is that it is optional to the states and need not be utilized by any given State if not desired.

I would appreciate your making my comments a part of the official record of the House Select Committee on Aging on this subject.

Sincerely yours,

GEORGE J. ALBANESE,
Commissioner.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES,
Trenton, N.J., July 23, 1982.

Re HSQ-502-P.

ADMINISTRATOR,
Department of Health and Human Services,
Baltimore, Md.

DEAR ADMINISTRATOR: The New Jersey Department of Human Services has reviewed your proposals in HSQ-502-P and agree with the underlying principle of

giving to the States the opportunity to exercise greater discretion in enforcing nursing home standards. We support this initiative and feel that States are in better position than the Federal Government to regulate nursing facilities in a cost efficient manner, while at the same time ensure the health, safety and comfort of all nursing home residents.

The following are specific comments on the salient points of HSQ-502-P:

1. *Consolidation of medicare and medicaid survey and certification provisions.*—There should be a single set of requirements for both programs which will eliminate confusion and problems of interpretation.

2. *Quarterly staffing reports.*—We agree that these reports are time consuming and that it will better serve the purpose if they are done at the request of the State Survey Agency rather than on a routine basis.

3. *Mandatory 90-day resurveys.*—We agree that the 90-Day Resurvey should be eliminated and that the follow-up be conducted by the State Survey Agency at a time they feel more feasible.

4. *Time-limited agreements.*—We agree with the elimination of the one-year time period. The State Survey Agency should have the authority to set time limits, based on needs up to certain maximums. This would allow the State Survey Agency to concentrate on facilities exhibiting repeated deficiencies. The current requirement that HCFA must approve Medicare certification of nursing homes and the State may only approve Medicaid nursing homes is extremely cumbersome, duplicative, and creates and inordinate waiting time for approval from HCFA.

5. *Cancellation clause provisions.*—We agree with the elimination of the automatic cancellation clause. However, there should be follow up by the State Survey Agency to ensure the correction of deficiencies.

6. *Flexible survey cycle.*— The Department of Human Services wholeheartedly supports the flexible survey cycle theory. Surveys should concentrate on those facilities exhibiting repeated problems and deficiencies, rather than a rote, time-consuming and fiscally imprudent process of surveying the majority of nursing facilities already in compliance with standards.

In reviewing the comments of the various interest groups and agencies appearing in the newspapers recently, there is an expression of fear that unless survey teams visit nursing facilities on a twelve (12) month cycle, patient care will suffer. I find this difficult to understand. As mandated by Section 1903(g)(1) (C) and (D) of the Social Security Act and promulgated by regulation in 42 CFR 456.601–613, the New Jersey Medicaid Program has a very comprehensive system of Utilization Review and Inspection of Care whereby professional staff of physicians, nurses and social workers are visiting all nursing homes almost on a daily basis. These professionals are speaking with patients, assessing their needs, listening to their problems and advocating for their benefit to ensure the highest quality of life possible. At the same time, the Medicaid Staff are required to measure the performance of each nursing home based on their ability to meet the individual care needs of each patient, and a written report is submitted on at least an annual basis to the nursing facility pointing out their strengths and weaknesses in providing quality of care to their patients. As you know, there is a severe fiscal penalty (42 CFR 456.656) levied against any State Medicaid Program not complying with the Inspection of Care (IOC) regulations, which speaks to the serious regard HCFA has toward continuous review of patients' needs in nursing facilities.

7. *Deemed status for SNFs, ICFs (excluding ICFs for the mentally retarded, and HHAs accredited by the Joint Commission on Accreditation of Hospitals (JCAH).*—We support HCFA's proposal to grant States the option of accepting JCAH accreditation for both Medicare and Medicaid in lieu of an additional survey by the State. We have experienced recently with certain State Psychiatric Hospitals in New Jersey that after a very intense review process by JCAH to successfully obtain accreditation, it was then necessary to separately request Medicare certification and await the scheduling of an on-site survey and a further long delay in awaiting final HCFA approval. Aside from the fact that there is a serious loss in both Medicare and Medicaid funds for the periods of delay between JCAH accreditation and Medicare/Medicaid approval, the separate survey by both JCAH and the State survey appear duplicative and fiscally unwise.

Thank you very much for the opportunity to comment on the proposed changes to 42 CFR 405, 431, 442, and 489 and 490.

Sincerely yours,

GEORGE J. ALBANESE,
Commissioner.

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